The health economy in Mexico

Leonardo Lomelí Vanegas

Abstract

The global health crisis caused by the coronavirus disease (COVID-19) pandemic has highlighted the important connection between the economy and health. This relationship exists at the microeconomic, macroeconomic and institutional levels, as health markets tend to suffer from market failures; health expenditure tends to increase as a percentage of gross domestic product (GDP), and its financing has long-term implications for public finances. In the case of Mexico, the creation of a public health system that is segmented —as a result of the social protection scheme applied since 1943, which has been reformed several times in recent years— has contributed to making access to health a major factor in inequality, playing a part in the multidimensional poverty of a significant segment of the population.

Keywords

Health, health economics, public health, public expenditures, health services, right to health, population, social welfare, health policy, Mexico

JEL classification

H41, H44, I10, I13, I14, I18, I38

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I. Introduction[1]

The coronavirus disease (COVID-19) pandemic caused by the SARS-CoV-2 virus has revealed the extent of the strengths and weaknesses of countries' health systems. The pandemic has also highlighted the oligopolistic or monopolistic nature of the main health-related markets, States' insufficient regulatory capacity at the domestic level, and a lack of global governance that is able to organize effective cooperation in situations such as this. For all these reasons, it is no exaggeration to say that the health economy has become a strategic area not only for economic analysis, but also for public welfare and global security.

The health economy emerged as a branch of the welfare economy. This explains why much of the available literature addresses this area of study from a microeconomic perspective and focuses on analysing markets for providing health services and for producing inputs and treatment technology and, more recently, on proposing resource allocation criteria for different medical procedures (Martínez, 2014). From a microeconomic perspective, a fundamental concern regarding the health economy is to correct market failures in the production of such goods and services. This entails different forms of State intervention in these markets; this can range from direct provision to regulation, or direct or indirect subsidization of production or consumption.

The health economy also has a macroeconomic dimension: health expenditure as a percentage of gross domestic product (GDP), or gross national product (GNP) depending on the country under analysis, tends to increase over time, and the financing of health services is a major concern for governments today. In addition, health is a variable that influences economic growth through human capital. Access to health services and their quality are fundamental variables in the population's well-being, affecting both the distribution of income and levels of multidimensional poverty. Therefore, the relationship between health, economic performance and social welfare is strategic, and one of the most promising areas of analysis for modern development theory. The experience of recent decades supports Angus Deaton's proposition that access to health, in addition to being a very important variable in explaining development, is a key factor in reducing or increasing inequality (Deaton, 2015).

II. The macroeconomics of health

The health economy has an increasingly significant macroeconomic dimension. In all countries, health expenditure is trending upwards in the long term, as a result of two transitions that are closely related to each other and to levels of development: the demographic transition and the epidemiological transition. The combined result is that the population is living longer and a larger proportion is suffering from chronic-degenerative diseases, causing a sustained rise in care costs, which in turn leads to increased health expenditure in the long term.

The demographic transition is characterized by a gradual ageing of the population, owing to increased life expectancy and changes in reproductive patterns, which lead to a transformation of age structures reflected in population pyramids. The increase in life expectancy is the result of the dissemination of hygiene measures that reduce the spread of certain diseases and the universalization of treatments that cure them. The changes in reproductive patterns arise from the increasing proportion of women in the labour market and from family planning; today, families choose to have fewer children, to have them later, or to have no children at all. Increases in school enrolment have reinforced this trend, as women have more information with which to plan their academic, professional and family

[1] Many thanks to Ismael Valverde Ambriz for his help and valuable comments.

lives (Welti, 2012). The epidemiological transition is also the result of successful prevention policies and access to treatments for infectious diseases, which are curable thanks to the progress in medical knowledge and pharmacology. In 1950, infectious diseases (gastroenteritis, influenza and early childhood diseases) accounted for most of the main causes of death in Mexico, but by 2013 chronic-degenerative diseases predominated, such as diabetes mellitus, ischemic heart diseases and malignant tumours (Soto-Estrada, Moreno-Altamirano and Pahua, 2016).

Public health systems were first created in the late nineteenth century in Mexico, but the process gathered pace after the Mexican Revolution. In 1917, the Department of Public Health was created, which in 1943 was merged with the Secretariat of Public Welfare to form the Secretariat of Health and Welfare (SSA). In that same year, President Manuel Ávila Camacho created the Mexican Social Security Institute (IMSS). These two institutions drove sustained development of the Mexican public health system, based on two pillars: formal workers in the private sector, assigned to the Mexican Social Security Institute, and those not entitled to contributory social security, assigned to the Secretariat of Health and Welfare (Martínez, 2013). In 1960, with the founding of the Social Security and Social Service Institute for State Workers (ISSSTE), a third pillar was created to serve government employees.

For decades, the Mexican State's strategy was to provide access to health services increasingly through social security agencies whose coverage was limited to workers in the formal sector of the economy, in particular, the Mexican Social Security Institute and the Social Security and Social Service Institute for State Workers. In line with this approach, the system to serve those not entitled to contributory social security was conceived as a transitional scheme. However, population dynamics prevented this goal from being achieved and, from the debt crisis and structural change in the 1980s onward, slow economic growth led to a shift away from this objective because of limited growth in formal employment. Consequently, at the beginning of the twenty-first century, Mexico's health expenditure was equivalent to a small percentage of GDP, which had implications both for demographic well-being and for key health and infrastructure indicators.

As shown in table 1, Mexico stands out among Organization for Economic Cooperation and Development (OECD) countries because it has one of the lowest levels of public spending on health as a percentage of total expenditure on health: the proportion of public spending is, together with Turkey's, one of the lowest among the countries in the sample, and below average for OECD countries and even lower than in other Latin American countries such as Argentina, Brazil, Colombia and Peru (PAHO, 2019). Household spending accounts for 41% of health expenditure, including the cost of medication —which represents a significant portion of health spending— and catastrophic medical expenses in health emergencies. In OECD countries, public spending on health care averages 71% of total health spending. Sweden and Japan finance 84% of health expenditure with public resources, while France, Germany, Turkey and the United Kingdom cover more than 75% with public expenditure. In contrast, the United States (50%) spends a similar percentage to Mexico (51%), but the amount of public spending and the proportion with respect to the size of the economy are both significantly higher in the United States.

Mexico also stands out as the country with the least investment in the health sector of the countries analysed: only 1.3% of total expenditure in 2018 was in health, equivalent to 0.1% of GDP. This amount contrasts with Mexico's shortfall in health infrastructure, as shown in table 2. In one crucial indicator —number of hospital beds per 10,000 inhabitants— Mexico is not only behind developed countries such as Germany and the United States, but also behind Latin American countries such as Brazil and Chile. It is also surpassed by other middle-income countries, such as Turkey. This lag is a result of limited investment in health infrastructure in recent decades, owing to insufficient investment in the health sector as a whole from the 1980s to the early twenty-first century.

Table 1
Mexico and selected countries of the Organization for Economic Cooperation and Development (OECD): health expenditure indicators, 2008–2018
(Percentages)

Countries	Annual percentage change in per capita health expenditure (2008–2018)	Financing system as a percentage of the total					Percentage of total public expenditure on health, 2018	Health expenditure from public sources as percentage of total health spending, 2018	Investment in health, 2018	
		Other	Household spending	Voluntary health insurance	Compulsory health insurance	Government systems			As a percentage of total health spending	As a percentage of GDP
Canada	2	2	15	13	1	68	19	73	5.6	0.6
Chile	5	...	34	6	58	2	17	50	2.7	0.2
France	1	1	9	7	78	5	15	77	5.1	0.6
Germany	2	2	13	1	78	6	20	78	9.6	1.1
Italy	1	1	23	2	...	74	13	74	4.1	0.4
Japan	2	1	13	2	75	9	23	84	10.4	1.1
Mexico	1	2	41	6	28	24	11	51	1.3	0.1
OECD	2	2	21	4	37	36	15	71	5.6	0.5
Spain	2	0	24	5	4	66	15	71	8.6	0.8
Sweden	2	1	15	1	0	84	19	84	5.1	0.6
Turkey	3	5	17	...	56	22	10	78	7.4	0.3
United Kingdom	1	2	16	3	0	79	19	79	3.2	0.3
United States	3	4	11	...	58	26	23	50	3.5	0.6

Source: Organization for Economic Cooperation and Development (OECD), OECD Health Statistics 2020 [online database] http://www.oecd.org/els/health-systems/health-data.htm.

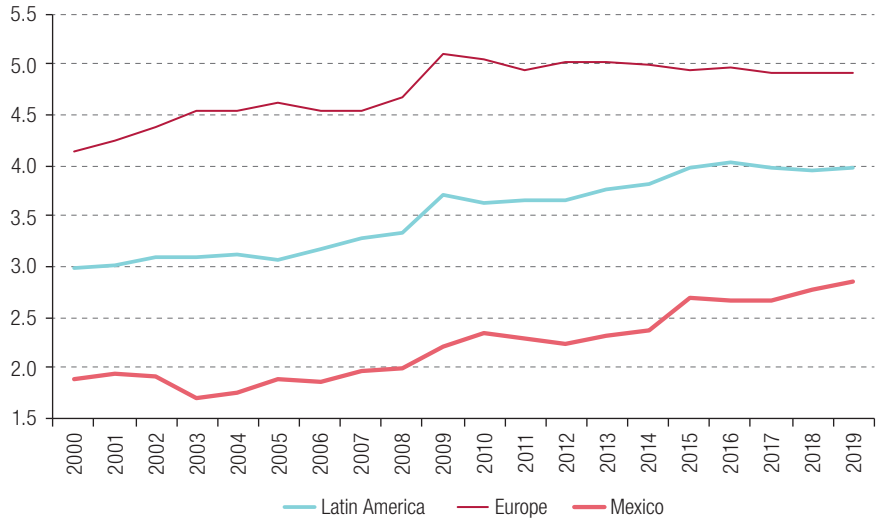
Table 2
Mexico and selected countries of the Organization for Economic Cooperation and Development (OECD): hospital beds per 10,000 inhabitants, 2019
(Number)

	Brazil	Chile	Germany	Mexico	Turkey	United States
2008	24	21	82.13	16	23.39	32
2009	24	21	82.42	16	23.98	31
2010	24	20	82.50	17	25.20	30
2011	23	21	82.24	15	25.34	30
2012	23	22	81.64	15	26.61	29
2013	23	22	82.78	16	26.56	29
2014	22	22	82.78	15	26.66	29
2015	22	22	83.00	15.2	27.00	29
2016						
2017						
2018						
2019	22	22	83.7	15	27	29

Source: World Health Organization (WHO), Global Health Expenditure Database (GHED), 2020 [online] https://apps.who.int/nha database.

These deficiencies exist because public spending on health in Mexico has remained below average for OECD countries, and even below the average for Latin America. Over the last 20 years, there have been two clear trends in public spending on health (before and after the crisis of 2008 and 2009): while in Europe and Latin America the trend was upward before the crisis, from 2009 onward it stalled in Europe and slowed in Latin America (see figure 1).

Figure 1
Latin America, Europe and Mexico: public expenditure on health, 2000–2019
(Percentages of GDP)



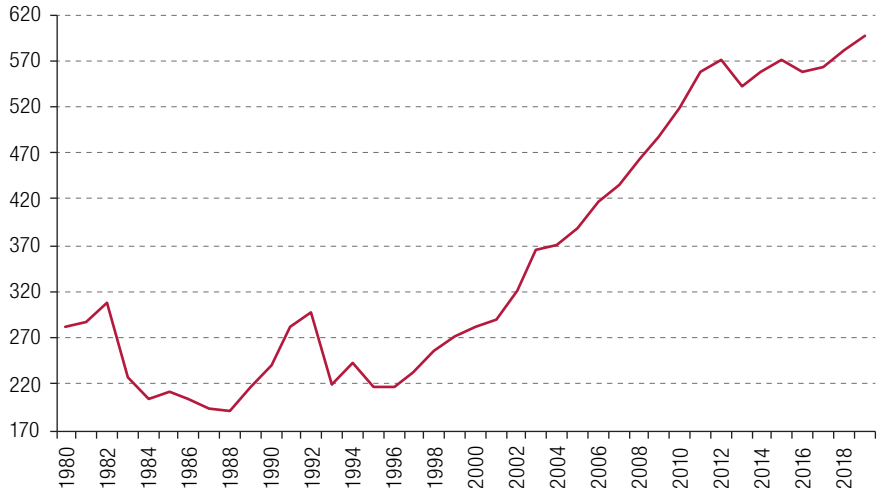
Source: World Health Organization (WHO), Global Health Expenditure Database (GHED), 2020 [online] https://apps.who.int/nha/database.

In contrast, in the first two decades of this century, public spending on health rose in Mexico, albeit with some fluctuations, an increase that was all the more significant considering that it occurred during a slow-growth period in the Mexican economy. For a little more than a decade, the increase in public spending on health was sustained in real terms. However, despite this effort, Mexico has not managed to reach the Latin American average for public spending on health as a percentage of GDP, let alone the European average. What is more, even the Latin American average does not meet recommended international standards. According to the Economic Commission for Latin America and the Caribbean (ECLAC), most countries in the region have underinvested in health:

> Central government spending on the sector, which in 2018 stood at 2.2% of regional GDP […] is far from the 6% of GDP recommended by the Pan American Health Organization (PAHO) to reduce inequities and increase financial protection within the framework of universal access to health and universal health coverage. Additional resources would help to strengthen the first level of care, with an emphasis on disease prevention (ECLAC, 2020a, p. 9).

Throughout recent history, public spending on health has fluctuated, reflecting the procyclical macroeconomic policy that has predominated in Mexico since 1982 (Ros, 2013), whereby social spending and investment have been reduced to lower overall public spending in times of crisis. As shown in figure 2, real public spending on health declined during crises and economic slowdowns, such as the debt crisis that began in 1982, which was exacerbated in 1986 by a fall in oil prices. After a period of recovery in the late 1980s and early 1990s, there was a further decline from 1993 onward, exacerbated by another crisis in 1995. In 1996, a recovery began that continued through to 2009, when cuts were made to the areas of social spending (mainly education and health) and investment (infrastructure and energy). It was at this time that the Government of Mexico made its greatest effort to provide services to those not entitled to contributory social security, which rather than shrinking was expanding owing to a downturn in formal employment. However, from 2012 onward, there was a clear slowdown in growth.

Figure 2
Mexico: public expenditure on health, 1980–2019
(Billions of Mexican pesos at 2018 prices)



Source: National Institute of Statistics and Geography (INEGI), "Salud", 2020 [online database] https://www.inegi.org.mx/temas/saludsat/.

There is no doubt that Mexico needs to allocate more public resources to health. The high percentage of spending that is borne by households reflects the continuing importance of access to these benefits for the well-being of the population and their impact on poverty and inequality. A lack of access to public health services exposes the population that receives insufficient and unstable income to poverty in the event of potentially catastrophic illness. Furthermore, the segmentation of the systems, with different ranges of services and care quality gaps, adds to the economic and social inequality that characterizes Mexico.

A public health system with universal coverage and a comprehensive range of services would do much to lower the risk of poverty, reduce inequality and strengthen social cohesion. For a system to be viable, it needs to be financed with general taxes, which is only sustainable in the long term with an exhaustive redistributive tax reform. The irony is that if no progress is made towards building this system, which may seem an ambitious goal, segmentation may prove more expensive in the long term, both economically, and because of larger gaps between those not entitled to contributory social security and those who are entitled to benefits from special social security agencies.

III. The microeconomics of health

According to 2018 records for Mexico's Health Sector Satellite Account, the health sector provided the equivalent of 5.7% of Mexico's GDP; 4.1% corresponded to the GDP of economic activities in the sector and 1.6% to the value of unpaid work relating to health care. For the GDP of economic activities in the sector, 71.9% was generated by the economic units that make up the sector and 28.1% corresponded to the monetary value of the unpaid work carried out by households to care for the sick. Of the goods required by the health sector, 80.2% were of domestic origin, 10.4% were imported and the remaining 9.4% corresponded to commerce and distribution margins. The goods and services account of the sector was in surplus, with net exports of 11.799 billion Mexican pesos, including significant exports of dressings and wound care supplies and other health-care goods. In the same year, the health sector created 2,204,897 new paid jobs, representing 5.1% of total national employment (INEGI, 2019).

While the health sector has surpluses in both the trade and service accounts, the related sector of drug manufacturing does not. The Mexican pharmaceutical industry has suffered ups and downs since the crisis of 2009, and its share of manufacturing GDP declined from 5.2% in 2003 to 3.2% in 2014. One of the reasons for this downturn is exchange-rate fluctuations —as around half of its inputs are imported— which has pushed up import costs. Imports of medicines and pharmaceutical inputs amounted to 70.607 billion Mexican pesos in 2018, while exports amounted to 22.143 billion Mexican pesos. The balance of trade in the same year amounted to 48.464 billion Mexican pesos. In terms of health sector imports, key items include health care equipment, dressings and wound care materials and glasses (INEGI, 2019).

In view of the weaknesses revealed by the current health crisis, industrial policy should prioritize the pharmaceutical industry and the sector that produces safety equipment and technology for health care. As the Executive Secretary of the Economic Commission for Latin America and the Caribbean (ECLAC), Alicia Bárcena, highlighted in a briefing for the member countries of the Conference on Science, Innovation and Information and Communications Technologies (a subsidiary body of ECLAC): "we have to bring science, technology and innovation closer to productive sectors […] such as in the case of manufacturing medical supplies, diverse products for health protection, tests to detect the virus, and critical medical equipment such as mechanical ventilators, among other items" (ECLAC, 2020c). In times of crisis such as 2020, reducing national dependence on medication and devices that are crucial for health care becomes a strategic area, and also opens up possibilities for industrial development, technological innovation and import substitution for the countries of the region.

IV. The challenges Mexico faces in guaranteeing the right to health

Despite the progress made by Mexico in terms of life expectancy, health care in the country is unsatisfactory, given that the public health-care system shows significant deficiencies in three core indicators: equality, quality and financial coverage, as shown in table 3.

Table 3
Mexico and Organization for Economic Cooperation and Development (OECD): indicators of equality, quality and financial coverage, 2019

Indicator	Mexico	OECD
Equality		
Health service coverage *(percentages)*	89.3	98.4
Financial protection *(percentages)*	51.3	71.0
Quality		
Effectiveness of basic services	85	225
Effectiveness of secondary services	27.5	6.9
Financial coverage		
Health expenditure per capita *(dollars)*	1 138	3 994
Health spending *(percentage of GDP)*	5.5	8.8

Source: Organization for Economic Cooperation and Development (OECD), *Health at a Glance 2019: OECD Indicators*, Paris, 2019.

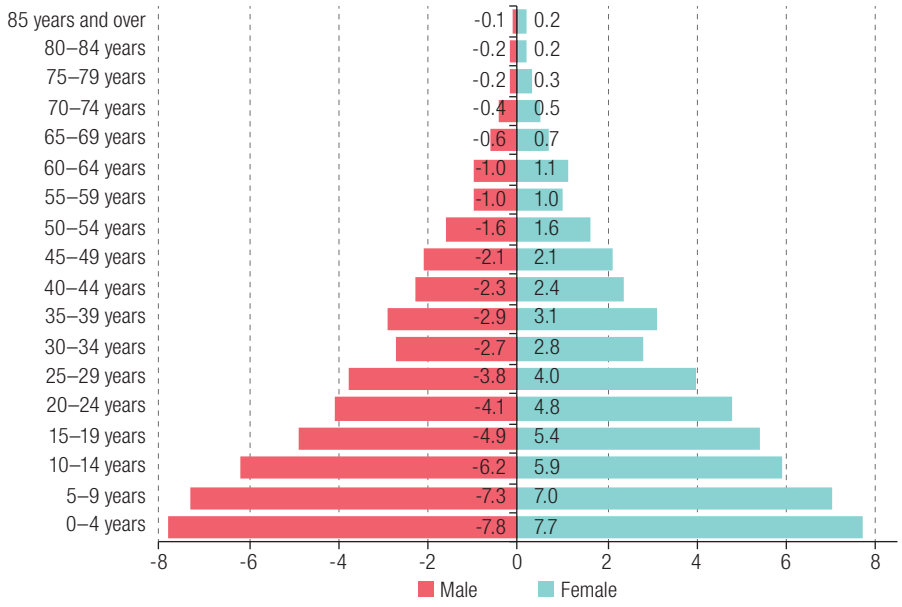
Note: Health service coverage is calculated as the percentage of the population eligible for basic services; financial protection is the percentage of the population aged over 15 years whose health expenditure is covered by public sources; The effectiveness of basic services can be discerned from the number of hospital admissions for asthma and chronic obstructive pulmonary disease (COPD) per 100,000 inhabitants, and the effectiveness of secondary services can be inferred from the 30-day mortality rate for myocardial infarction per 100,000 inhabitants.

These gaps are not only apparent in international comparisons, they are also worsening within the country. Inequalities and contrasts remain key characteristics of Mexico and occur in access to health and health infrastructure, both among individuals and social groups and among regions. It can be argued that, as a country's income level determines its health sector conditions, Mexico will be able to aspire to better health levels as its economic performance improves. However, several studies show that health levels also directly affect economic growth. As recently stated by ECLAC and the Pan American Health Organization (PAHO), "sustainable economic growth is a central component of people's health and overall well-being. At the same time, the protection and promotion of the population's health should be the basis for a strategic initiative aimed at long-term growth and development" (ECLAC/PAHO, 2020, p.16).

In the case of Mexico, research by David Mayer-Foulkes (Mayer-Foulkes, 2001) —on the relationship between life expectancy and mortality rates (among different age groups) and economic growth— maintains that advances in health contributed around one third of the (potential) growth recorded in Mexico in the period 1970–1995. Population growth and a rising life expectancy throughout the twentieth century allowed the country to grow from 13 million inhabitants in 1900 to over 100 million in 2000. In addition, over the course of two decades, from 1940 to 1960, Mexico was transformed from an overwhelmingly rural country to a predominantly urban one (Welti, 2012). There is no doubt that this major transformation would not have been achieved without the investments in health made by the government in the post-revolution period, even if they were insufficient.

The system was developed during the rapid industrialization and urbanization of the decades following the Mexican Revolution. This also made it easier to disseminate general hygiene measures and treatments, at a low cost, for the most common infectious diseases. These improvements increased life expectancy at birth. As a result, by 1950, significant progress was being made in reducing child and maternal mortality, which had an impact on population growth. The only discontinuity in an almost perfect population pyramid was, according to the census for 1950, in the group of those born during the critical years of the Mexican Revolution (1913–1916) and the Spanish Flu (1918–1919) pandemic (see figure 3).

Figure 3
Mexico: population pyramid, 1950
(Percentages)

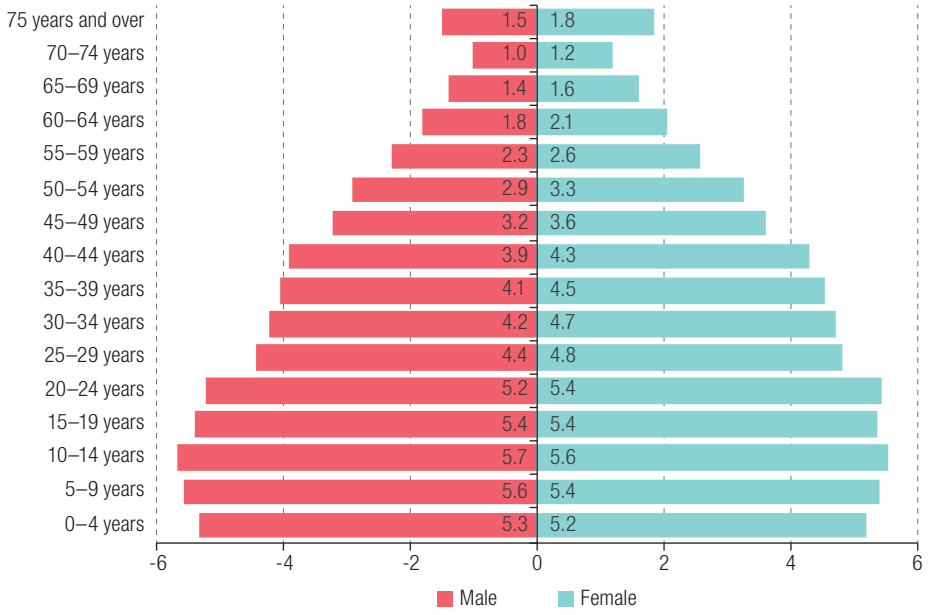


Source: National Institute of Statistics and Geography (INEGI), Séptimo Censo General de Población, Aguascalientes, 1950.

The social policy adopted by the State in the post-revolution period, based on including the population in health protection systems through registration of beneficiaries and their families with social security agencies, entered a crisis in the 1980s. It had already become clear that these agencies struggled to absorb a portion of the informal economy, but at this time the economy began to fluctuate, affecting formal employment and bringing the previous growth in coverage to a halt. In addition, quality deteriorated, as a combined result of policies of lower spending in the 1980s and higher costs of health care. This occurred amid a demographic transition, when there was a larger population of working age and the dependent population under 15 years of age was shrinking, resulting in a demographic dividend that was squandered owing to slow growth in the Mexican economy. As the country was unable to generate enough jobs in the formal sector, the main escape valves were emigration and informality (Lomelí and Vázquez, 2016).

Mexico's population structure, in which children and youths predominated in 1950, was substantially different by 2015, as a result of the success of the population policy launched through the 1974 General Act on Population, the creation of the National Population Council (CONAPO) and the systematic roll-out of family planning campaigns. These policies reduced population growth, as reflected in a narrowing base of the population pyramid, resulting in expansion of the working-age population and the consequent reduction in the dependency ratio. These changes are clear in the 2015 population pyramid, despite an upturn in the birth rate in the 2000s (see figure 4).

Figure 4
Mexico: population pyramid, 2015
(Percentages)



Source: National Institute of Statistics and Geography (INEGI), Encuesta Intercensal 2015 [online database] https://www.inegi.org.mx/programas/intercensal/2015/default.html.

Despite the reforms, and an average real annual increase of 4.4% in per capita health expenditure between 1997 and 2007 (above the average of 4.1% recorded in OECD countries), in Mexico there are asymmetries between the care provided by the health system and the needs of the population. Because of the crisis in the 1980s and its aftermath in the 1990s, despite the progress made in the twentieth century, some deficiencies remain, with new challenges arising from the demographic and epidemiological transitions. Together, these impediments maintained and exacerbated the problems

caused by the fragmentation of the health system (institutions and programmes), insufficient and unequal coverage, inefficient resource allocation, poor utilization of medical units and financial imbalances. Added to these problems is the unequal distribution of health infrastructure in Mexican territory, which reproduces regional inequalities and coincides with the geographical distribution of poverty (Lomelí, Flores and Granados, 2012).

In 2016, public spending accounted for 52% of total health expenditure, and financed two key types of institutions: those that provide services to people who are eligible because of their employment status (Mexican Social Security Institute, Social Security and Social Service Institute for State Workers, and the health services of Petróleos Mexicanos (PEMEX), the Secretariat of Defence (SEDENA) and the Secretariat of Maritime Affairs) and programmes for the population without social security. Private spending in the same year amounted to 48% of the total; more than 80% of private expenditure was out-of-pocket and the rest was covered by private insurance systems. Leaving aside international comparisons and the lack of universal parameters for optimal investment in health in relation to the size of an economy, it is important to ask whether Mexico is investing appropriately (considering total expenditure, financing sources and distribution). The pandemic has made it clear that investment in health is not only lower than needed in Mexico, based on the country's level of development and needs, but also that the distribution of investment does not contribute to reducing disparities in health indicators.

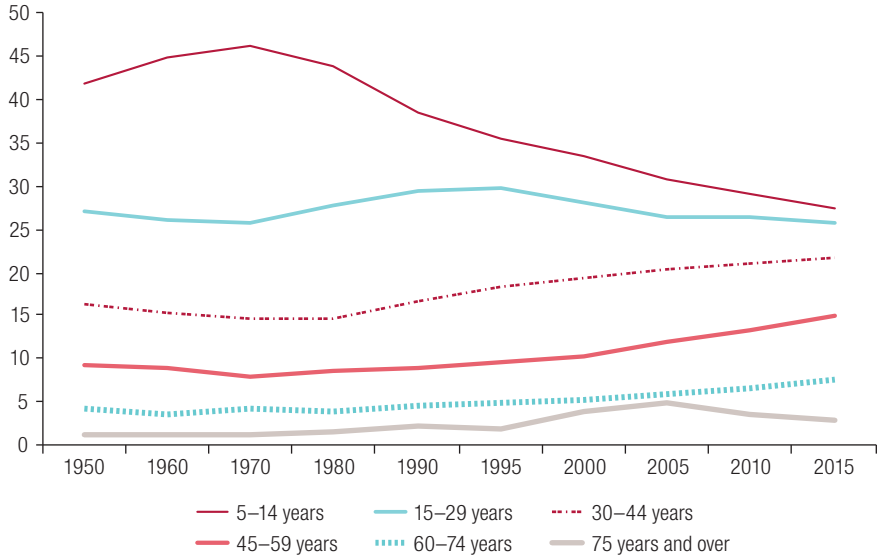
The increase in real terms in federal resources for the population without social security has not resolved the imbalance between public spending on the insured and the uninsured. In 2004, the government launched the Seguro Popular insurance scheme, which was theoretically financed from three sources: federal resources allocated by the Secretariat of Health, State resources and family instalments, from which families from the poorest 40% of households were exempt. In 2009, the resources available for Seguro Popular accounted for 48.6% of total expenditure in section 12 (health) of the Federal Budget, at 41.368 billion Mexican pesos, 5.7% more than in 2008. In 2019, Seguro Popular received 80.144 billion Mexican pesos, representing 64.5% of the resources allocated to section 12 of the budget. This significant increase in resources meant that in 2017 public spending on health was equal to 52% of total health spending. However, total per capita expenditure for people without social security was 3,954.9 Mexican pesos compared to 5,644.7 Mexican pesos for those with social security, once again reflecting the inequality problems caused by segmentation of the public systems (CONEVAL, 2020).

In November 2019 the federal government announced that the Seguro Popular scheme was to be dissolved and merged into the Institute of Health for Welfare (INSABI). As explained on its official website (Institute of Health for Welfare, 2020), the purpose of the Institute is to provide "free, quality health services to all people in the country who do not have social security", in accordance with "criteria of universality, equality and inclusion". In addition, "beneficiaries of the Institute of Health for Welfare shall receive unrestricted medical services because there shall be universal care for all conditions, including those that entail catastrophic costs". It also aims to "guarantee and improve care in public health services", ensure "the supply of medicines and sufficient equipment for the care of beneficiaries at all levels of health care", as well as "rehabilitating and expanding the medical infrastructure".

It is undeniable that health services must be extended further and that public programmes must be effectively integrated and interlinked. However, it is not clear whether dissolving the Seguro Popular scheme and the creating the Institute of Health for Welfare is the best means of extending coverage. Moreover, the question arises whether the creation of a new programme is not fuelling segmentation of public services, heterogeneity of benefits and operational inefficiency of the national health system. Without a doubt, the budgetary priority given to this new organization, and proper organizational and institutional design, are crucial to it fulfilling its intended purpose.

Coverage is no trifling issue in a country facing a progressively ageing population. It is not yet a problem, but will be in three decades' time. If current demographic trends continue, by the mid-twenty-first century the percentage of adults aged over 60 years without social security in need of health services will have increased significantly. As shown in figure 5, since the 1960s, the under-15 population group has shrunk swiftly, while the over-30 group has been growing rapidly since the 1980s. This trend suggests a progressive population ageing that will necessitate allocation of more resources to both health and social security by the middle of the twenty-first century.

Figure 5
Mexico: population distribution by age group, 1950–2015
(Percentages of the total)



Source: National Institute of Statistics and Geography (INEGI), Encuesta Intercensal 2015 [online database] https://www.inegi.org.mx/programas/intercensal/2015/default.html.

Demographic trends indicate population ageing and the ongoing epidemiological transition points to higher health-care costs in the future. The emergence of new diseases, in particular resulting from the rapid spread or mutation of viruses such as SARS-CoV-2, will necessitate increased investment in health research and the development of new prevention and care mechanisms, as well as stronger capacities of curative care services. This is why the challenges of increasing coverage, reorganizing system priorities and improving care quality are interrelated.

In addition to these considerations, access to health services remains a factor in the poverty and inequality for much of the Mexican population. According to the National Council for the Evaluation of Social Development Policy (CONEVAL, 2020), based on data from the 2018 National Household Income and Expenditure Survey, in Mexico in that year 20.2 million people had no access to health services and 71.7 million had no access to social security. These data are of interest because the population not affiliated with social security organizations was covered by the Seguro Popular scheme and was protected for fewer medical services —294 according to its latest catalogue, dated September 2019 (CNPSS, 2019)— than affiliates of the Mexican Social Security Institute or the Social Security and Social Service Institute for State Workers.

But even these data do not reveal the full extent of the health-care problem in Mexico. According to the National Institute of Statistics and Geography, in 2020, 82.2% of those who are currently not entitled to contributory social security will be affiliated with social security organizations or public health

services, while 23.1% will use private medical services (INEGI, 2019). The second percentage includes those whose socioeconomic status enable them to afford private health care and those who resort to it in emergencies because, despite being entitled to State health care, they are unwilling or unable to wait their turn to be treated by public institutions. Indeed, owing to a lack of resources, waiting times have become the main means of rationing used by public health services to manage excess demand, given their insufficient supply. The challenge for the Institute of Health for Welfare is not only to increase coverage, but also to increase the number of medical services covered and the capacity to provide care, reducing waiting times.

As the health emergency of 2020 has shown, another important aspect to consider is the strategic nature of substituting imports of medicines and medical devices. According to ECLAC, "the disruption of several global value chains has shown the risks of heavy regional dependence on imported manufactures. This is particularly evident in the severe limitations on the supply of essential products for combating COVID-19, following restrictions imposed by most of the region's major suppliers" (ECLAC, 2020b, p. 19).

V. Conclusions

The main challenge in guaranteeing the right to health is to achieve universal coverage without causing new asymmetries in quality and supply of public health system services, which is a result of their segmentation. For the Institute of Health for Welfare to fulfil its purpose, it will need sufficient material, financial and human resources, and it must be an organization that is able to operate in the short term for the benefit of those not entitled to contributory social security, but is also flexible enough in the long term to integrate and interlink with the other public institutions in the sector, to build a genuinely national health system.

Human development does not and cannot occur without a universal and comprehensive health system. The State cannot renounce its responsibility to ensure access to health for all citizens. A fiscal effort must therefore be made to finance such a national health system. The market would only mirror the asymmetries in income distribution in access to health services. It is therefore clear that market forces or trade negotiations do not determine the health level of the population, and cannot be allowed to do so. The State has the inescapable task of formulating policies to protect the health of Mexicans. In fact, it is a duty enshrined in the country's Constitution, article 4 of which recognizes the right to health. It is the responsibility of everyone, and in particular of legislators, to design appropriate mechanisms to guarantee this right.

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