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Ethical and Human Rights Foundations of Health Policy: Lessons from Comprehensive Reform in Mexico

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Abstract

This paper discusses the use of an explicit ethical and human rights framework to guide a reform intended to provide universal and comprehensive social protection in health for all Mexicans, independently of their socio-economic status or labor market condition. This reform was designed, implemented, and evaluated by making use of what Michael Reich has identified as the three pillars of public policy: technical, political, and ethical. The use of evidence and political strategies in the design and negotiation of the Mexican health reform is briefly discussed in the first part of this paper. The second part examines the ethical component of the reform, including the guiding concept and values, as well as the specific entitlements that gave operational meaning to the right to health care that was enshrined in Mexico's 1983 Constitution. The impact of this rights-based health reform, measured through an external evaluation, is discussed in the final section. The main message of this paper is that a clear ethical framework, combined with technical excellence and political skill, can deliver major policy results.

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Introduction

In this paper, we discuss the use of an explicit ethical and human rights framework to guide a case of successful health system reform: Mexico's 2003 changes to the country's General Health Law, which were intended to provide social protection in health to the entire Mexican population. This reform was designed, implemented, and evaluated by making use of what Michael Reich has identified as the three pillars of public policy: technical, political, and ethical.[1] In the first part of the paper, we briefly describe the use of evidence and political strategies in the design and negotiation of Mexico's health reform. In the second part, we concentrate on the discussion of the reform's ethical component. In the third part, we examine the impact of this rights-based health reform as measured through an external evaluation. Our analysis builds on and expands several ideas presented in two previous pieces.[2] Our main message is that a clear ethical framework, combined with technical excellence and political skill, can drive positive social transformation.

Origins, content, and negotiation of the Mexican health reform

The technical pillar of Mexico's health reform was built on the use of rigorous evidence. Much of this evidence was derived from the adoption and local adaptation of knowledge-related global public goods (for example, the burden of disease methodology, national health accounts, national surveys of household income and expenditures, and World Health Organization's framework for health system performance). Coupled with national data, these instruments revealed that Mexico's health system—like that in so many other developing countries—had not kept up with the pressures stemming from a complex and protracted epidemiological transition, whereby malnutrition, common infections, and reproductive health problems coexist with noncommunicable disease and injury.[3] With half of its population uninsured, Mexico was facing an unacceptable paradox: while promoting health was a critical factor in the government's battle against poverty, a large number of households were becoming impoverished by expenditures on health care services and drugs. This evidence was used to generate advocacy tools to promote a reform introducing a new public insurance scheme—known as Seguro Popular—that would provide regular access to comprehensive health care with financial protection to the non-salaried population.

Today, Seguro Popular protects over 53 million Mexicans who had previously been excluded from conventional social insurance.[4] If we add to this figure those enrolled in social security institutions (49.5 million) and those with private health insurance (8 million), we can state that Mexico, with a population of around 120 million, is on track to reach universal social protection in health.[5]

Evidence can empower policy makers with convincing means to challenge the status quo and promote change. In this way, it also helps build the political pillar of reform. In the Mexican case, this pillar demanded the development of a consensus among various stakeholders through the active conciliation of interests among federal and local authorities, trade unions, legislators, and political parties.[6] The consensus-building process culminated in 2003, when the Mexican Congress approved a major legislative reform to establish a system of social protection in health that would be operationalized through Seguro Popular.[7]

Needless to say, the construction of the political pillar does not end with the enactment of new laws; rather, it must continue into the implementation phase. To this end, the new insurance scheme was deployed gradually to allow the necessary time to generate additional political acceptance.[8] This is yet another example of how the technical and political pillars reinforce each other.

Ethical foundations of the Mexican health reform

Health systems reflect ethical assumptions. Consciously or unconsciously, explicitly or implicitly, these assumptions are expressed in the distribution of health care resources and benefits, and in the organization of institutions. For this reason, every attempt to reform the health system should

begin by asking which values it aims to promote, in addition to formulating technical proposals and political strategies.[9] Hence, the Mexican reform was framed on the basis of a guiding concept, "the democratization of health," and a set of values linked to the notion that health care is not a commodity or a privilege but a social right.

The democratization of health

Like most countries in Latin America in the late 20th century, Mexico witnessed a trend toward democratization that was part of what Samuel P. Huntington calls "democracy's third wave."[10] After several political and electoral reforms, the party that had ruled Mexico for most of the 20th century lost the presidential election in 2000.[11] This election helped establish a real multiparty system based on the design and implementation of trustworthy electoral mechanisms.[12]

The shift in power that took place in 2000 was an indication that Mexico had made major progress in the exercise of civil and political rights. The following step was to reduce inequalities by creating the conditions for the universal and effective exercise of social rights, including the right to health care.[13]

Health authorities in Mexico identified the opportunities offered by this unique moment and embraced the "democratization of health" as its core purpose, thereby placing health reform within the wider political agenda of the government. In fact, the subtitle of the *National Health Program 2001–2006* was "The Democratization of Health: Towards a Universal Health System."[14]

According to Guillermo O'Donnell and Philippe Schmitter, "democratization" implies application of the norms and procedures of citizenship to those institutions that have been managed by other principles, such as coercive control, social tradition, ruling of specialists, or bureaucratic processes.[15] In Mexico, previous governments had provided comprehensive health care and other benefits (such as old-age pension, unemployment insurance, and disability benefits) only to certain groups closely associated with the old regime (mostly the unions of salaried, industrial workers, and civil servants). The process of democratization offered the opportunity to extend these benefits to all citizens.

The term "citizen," in fact, is related to a range of rights and duties as defined within a constitution.[16] In his seminal work *Class, Citizenship, and Social Development*, Thomas Humphrey Marshall recognizes three categories of rights involved in the idea of citizenship: civil, political, and social.[17] According to Marshall, citizenship culminates in the effective exercise of social rights, which have been defined as the set of legal dispositions whose purpose is to protect individuals and social groups who usually live in conditions of economic disadvantage, in order to guarantee their coexistence in a just order.[18] He argues that all members of a society should enjoy at least a basic level of socio-economic and cultural well-being.

Health care as a social right

The idea of health care as a social right was incorporated into the Mexican Constitution in 1983. Paragraph 3 of Article 4 states the following:

> *Every person has the right to health protection. The law will define the ways and means for access to health services and will establish the concurrence of the Federation and the federated entities in matters of public health.*[19]

The addition of this paragraph to Article 4 was celebrated as a breakthrough, but appeals to caution regarding its immediate impact were also raised. The Mexican Constitution has three types of norms: positive, which create rights and obligations; organizational, which establish the arrangement of constitutional institutions; and programmatic, which generate action guidance for constituted powers.[20] The right to the protection of health is considered a programmatic provision and, as such, only a guide for public action. This meant that many of the beneficiaries of this right could not force the state, through trial, to comply with what was established in the provision. Only salaried workers and their families, who were protected by secondary laws (the social security law for workers

in the private sector and the social security law for civil servants), were able to effectively exercise the right to the protection of health.

The declaratory nature of the right to health was not perceived as an obstacle by those involved in its integration into the Mexican Constitution. As José Francisco Ruiz-Massieu, legal scholar and senior official of the Ministry of Health in the early 1980s, wrote in an article published in 1983, "Those working with legal norms know that the law is more than an instrument of coercion . . . . [I]t is a representation of the future, a creator of the social future, because it is the motor of political dynamics."[21] In closing, he called for an acceleration of change in Mexican society in order to democratize it and thus create the conditions for the universal and effective exercise of social rights.

In sum, in 1983 the Mexican Constitution formally recognized the right to health care, but its actual implementation was benefiting only certain sectors of the population. A definition of the entitlements ensuing from this legal norm and of the financial and organizational instruments necessary for translating these entitlements into comprehensive health services for all were still missing.

Values of the Mexican health reform

The definition of these entitlements, or guaranteed benefits, in the 2003 Mexican reform was grounded on the explicit adoption of five values: social inclusion, equality of opportunity, financial justice, individual autonomy, and social responsibility.[22]

The premise of "social inclusion" is that all human lives have the same value and that health systems ought to constitute institutional spaces where all citizens, regardless of socio-economic, labor, or migratory status, receive similar care for comparable needs.

"Equal opportunity" is based on Amartya Sen's concerns about "the real opportunity that we have to accomplish what we value."[23] Access to health care, in this sense, should help each generation enter life with the same opportunities.

"Financial justice" implies that individuals contribute to the health system according to their capacity to pay and that they receive health care services according to their health needs. A just health system is financed in such a way that health care services are free at the point of delivery, and a large enough risk pool is aggregated to facilitate three types of solidarity: risk solidarity (between the healthy and the sick), generational solidarity (between the young and the old), and distributive solidarity (between the wealthy and the poor).

The fourth value, "individual autonomy," means that every person enjoys the freedom to decide what is most appropriate for him or herself, a prerogative that the family unit assumes in the case of minors and of people with limitations in their capabilities to decide.

Finally, "social responsibility" places restrictions on the freedom proposed by the previous value. This is particularly important in the case of goods, such as health services, that exhibit "externalities"—that is, consequences for others of an individual's decisions. Thus, a neglect to care for one's own health can have an effect on other persons.

From values to entitlements

The values discussed above molded the ethical foundation for the establishment of a system that provides, through Seguro Popular, comprehensive health care with financial protection to all those Mexicans who had been excluded from the benefits of social insurance: the non-salaried population, which includes informal workers, the self-employed, the unemployed, and those outside the labor force. The bulk of the new insurance scheme is financed with public resources, with a small portion funded through family contributions that depend on income level and are waived for the poorest 40% of the population.

One of the most significant aspects of Seguro Popular's financial structure is its point of departure: the identification and costing of the health care benefits that would give operational meaning to the right to health care enshrined in the Mexican Constitution. The guaranteed benefits of Seguro Popular comprise two sets of interventions: first, a package of 280 essential interventions (as of December 2014) for health conditions of high incidence and low cost, including all health care

services offered at clinics and general hospitals of the Ministry of Health; and second, a package of 60 high-cost interventions that cover diseases that can potentially generate catastrophic costs for individuals and households, including treatment for HIV/AIDS, cancer in children, cervical and breast cancer, and myocardial infarction, among others.[24]

The moral implications of the use of a package of essential interventions in a reform process that stresses equity and social justice should not be overlooked. Essential health packages have been formulated as a priority-setting tool.[25] In contexts of scarce resources, cost-effectiveness analyses have been used to identify those public health and health care interventions that provide the "best value for money." These interventions are usually provided as a "safety net" or "guaranteed minimum" to the poor. In the Mexican reform case, the adoption of such tools has been enriched by including additional criteria in priority setting, by extending their application to quality assurance, and by incorporating them into a universal coverage framework based on the explicit definition of entitlements.

First, essential interventions were selected using cost-effectiveness analysis and social acceptability criteria. The purpose was to adapt these interventions to the norms governing the behavior of health professions and to broader social preferences, which were identified through consultative procedures. Second, the intervention packages have been used as a quality assurance tool designed to guarantee that all necessary inputs are available and that services are provided following standardized protocols. In fact, the new law requires that every health facility providing services to Seguro Popular beneficiaries be accredited or certified. Accreditation is based on having the required physical, material, and human resources to deliver the specified interventions. Finally, the packages have empowered citizens by making them aware of their health benefits. In fact, if necessary, these essential services can now be demanded in a law court.

The use of packages of essential health services in Mexico aims to merge two approaches regarding the distribution of health care benefits that, until now, have been portrayed as mutually incompatible: the technocratic approach, which offers practical alternatives but pretends to be morally neutral, and the rights-based approach, which has a solid value foundation but lacks operational support.[26]

Impact of a rights-based reform

Another distinctive component of the Mexican health reform was an external evaluation that was embedded in the original reform design; it was not an afterthought but a core component of this public policy.

Taking advantage of the phased rollout of Seguro Popular, a community trial was implemented in 2005 in over 38,000 households. One thousand health clusters (population units assigned to an ambulatory health facility) in seven states were matched on the basis of socio-economic and demographic variables. One hundred paired clusters were then randomly selected in communities where affiliation to Seguro Popular was being promoted. Fifty clusters, also randomly selected, received insurance coverage in a first stage (the treatment group). The other 50 clusters received the intervention in a second stage (the control group). In each cluster, 380 households were surveyed at baseline to collect information on the expected outcomes, focusing initially on health service utilization and financial protection. The first follow-up measurement was implemented a year later.

This community trial—which was "one of the largest randomised health-policy experiments ever"—revealed that Seguro Popular was reducing out-of-pocket expenditures and providing protection against excessive health expenditures, especially for the poorest households.[27]

Evidence from other studies also shows progress in national figures for out-of-pocket spending, which declined from 52% of Mexico's total health expenditure in 2001 to 44% in 2012, and for catastrophic and impoverishing health care expenditures, which show a clear downward trend between 2000 and 2010.[28] Additional studies have also revealed that those affiliated to Seguro Popular have a higher probability of service use conditional on perceived need than uninsured individuals and

that effective coverage for a set of interventions (antenatal care, immunizations, treatment of diarrhea and acute respiratory infections in children, breast and cervical cancer screening, and treatment of hypertension, among others) has improved since the reform.[29]

These evaluations and studies exemplify the possibility of applying rigorous research designs to advance our understanding of large-scale social interventions that improve the effective exercise of the right to health care. In fact, these types of evaluations—embedded, impact evaluations with quasi-experimental designs—should be used to assess the policies that are being designed and implemented worldwide as part of the global search for universal health coverage. Furthermore, in addition to measuring impacts on health conditions and financial protection, evaluations of universal health coverage initiatives should also use qualitative methods to ascertain crucial policy processes and outcomes, such as the legislative structures that favor its design; the historical, political, and organizational contexts in which these policies are negotiated; and the empowerment of health care users that can be generated.[30] Comprehensive mixed methods offer the best opportunity to capture the full complexity of reform processes and outcomes.

Conclusion

The global movement toward universal health coverage is advocating for the transformation of health care into a right that can be effectively and universally exercised. This can be aided by the use of an ethical platform in the design, negotiation, and implementation of health policies intended to expand health care coverage.

Mexico's recent health reform demonstrates that a rights-based approach to health care can produce significant policy results. The use of technical evidence was a crucial component of this reform. However, its approval in Congress also demanded effective political strategies that were strongly aided by the use of a solid ethical platform.

An additional innovative component of the Mexican reform was the implementation of an external evaluation and several studies that documented the expansion of coverage and the positive impact of Seguro Popular on several health indicators, most notably those related to financial protection. While these studies were not intended to attribute such impact to the use of a human rights-based approach, we can reasonably conclude that building a solid ethical pillar contributed to the positive results achieved. Equally important has been the way in which the reform effort has promoted and informed public deliberation on the crucial role of health in a democratic society.

References

1. M. Roberts, W. Hsiao, P. Berman, et al. *Getting health reform right: A guide to improving performance and equity* (New York: Oxford University Press, 2004).

2. J. Frenk and O. Gómez-Dantés, "Ideas and ideals: Ethical basis of health reform in Mexico," *Lancet* 373/9673 (2009), pp. 1406–1408; J. Frenk and O. Gómez-Dantés, "The democratization of health in Mexico: Extending the right to health care," in A. Clapham and M. Robinson (eds), *Realizing the right to health* (Berne: Ruffer and Rub, 2009), pp. 463–471.

3. J. Frenk, J. L. Bobadilla, J. Sepúlveda, et al., "Health transition in middle-income countries: New challenges for health care," *Health Policy and Planning* 4/1 (1989), pp. 29–39.

4. Secretaría de Salud, *Sistema de Protección Social en Salud: Informe de resultados: Enero–junio 2013* (Mexico City: Secretaría de Salud, 2013). Available at http://gaceta.diputados.gob.mx/Gaceta/62/2013/ago/Inf_Salud-20130816.pdf.

5. Instituto Nacional de Estadística y Geografía, *Encuesta Nacional de Empleo y Seguridad Social 2013: Principales resultados* (Aguascalientes, Mexico: Instituto Nacional de Estadística y Geografía, 2014). Available at http://www.inegi.org.mx/prod_serv/contenidos/espanol/bvinegi/productos/encuestas/hogares/eness/2014/702825058777.pdf; I. Santa Rita, "Seguros de gastos médicos, a la medida," *CNN Expansión* (August 15, 2013). Available at http://www.cnnexpansion.com/mi-dinero/2013/08/15/un-seguro-de-gastos-medicos-a-la-medida; Central Intelligence Agency, *The World Factbook: Mexico*. Available at https://www.cia.gov/library/publications/resources/the-world-factbook/geos/mx.html.

6. O. Gómez-Dantés, M. Reich, and F. Garrido-Latorre, "Political economy of the negotiation of the expansion of social protection in health in Mexico," *Health Systems and Reform* 1/3 (2015), pp. 207–216.

7. J. L. González, K. Ortiz García, and V. Cardona, "El Senado aprueba el Seguro Popular,"

ImagenMedica.com.mx (April 24, 2003). Available at http://www.imagenmedica.com.mx/portal/index.php/reportajes-menu/reportajes-2003/125-abril-2003/648-el-senado-aprueba-el-seguro-popular; J. Arvizu, "Aprueban la creación del Seguro Popular," *El Universal* (April 25, 2003). Available at http://www.eluniversal.com.mx/nacion/96042.html.

8. Gómez-Dantés et al. (see note 6).

9. A. Donabedian, *Aspects of medical care administration: Specifying requirements for health care* (Cambridge, MA: Harvard University Press, 1976), pp. 1–30.

10. S. Mainwaring, *The consolidation of democracy in Latin America: A rapporteur's report*, Kellogg Institute Working Paper 73 (Notre Dame, IN: Kellogg Institute, 1986). Available at http://kellogg.nd.edu/publications/workingpapers/WPS/073.pdf; S. P. Huntington, "Democracy's third wave," *Journal of Democracy* 2/2 (1991), pp. 12–34.

11. J. Woldenberg, "Democracia y desesperanza," *Letras Libres* 192 (2014), pp. 21–**24.**

12. R. Bartra, "La corrupción corroe la democracia," *Letras Libres* 193 (2015), pp. 22–23.

13. A. Sen, "Why and how is health a human right?" *Lancet* 372/9655 (2008), p. 2010.

14. Secretaría de Salud, *Programa Nacional de Salud 2001–2006: La democratización de la salud: Hacia un sistema universal de salud* (Mexico City: Secretaría de Salud, 2001).

15. G. O'Donnel and P. Schmitter, *Transiciones desde un gobierno autoritario (*Buenos Aires: Paidos, 1991), pp. 22–23.

16. R. A. Scruton, *A dictionary of political thought* (London: Macmillan, 1996), pp. 71–72.

17. T. H. Marshall, *Class, citizenship, and social development* (New York: Doubleday Anchor Books, 1965).

18. M. de la Cueva, *Derecho mexicano del trabajo* (Mexico City: Porrúa, 1977).

19. Constitution of Mexico, 2009 (as amended), Art. 4(3).

20. P. Biscaretti di Ruffia, *Introducción al derecho constitucional comparado* (Mexico City: Fondo de Cultura Económica, 1975), pp. 321–322.

21. J. F. Ruiz-Massieu, "El contenido programático de la Constitución y el nuevo derecho a la protección de la salud," *Salud Pública de México* 25/4 (1983), pp. 353–357.

22. J. Frenk, "Ethical considerations in health systems," in M. Marinker (ed), *Constructive conversations about health: Policy and values* (Oxford: Radcliffe Publishing, 2006), pp. 165–175.

23. A. Sen, *Inequality reexamined* (Cambridge, MA: Harvard University Press, 1992).

24. Comisión Nacional de Protección Social en Salud, *Catálogo Universal de Servicios Esenciales de Salud: Anexo I* (Mexico City: Comisión Nacional de Protección Social en Salud, 2014). Available at http://www.seguro-popular.gob.mx/images/Contenidos/gestion/Anexo%20I%202014.pdf; Comisión Nacional de Protección Social en Salud, *Fondo de Protección contras Gastos Catastróficos.* Available at http://www.repssver.gob.mx/uploads/file/contenido_extra/gastos_catastroficos/2014/Anexo%201_%20FPCGC%202014.pdf.

25. World Health Organization, *Essential health packages: What are they for? What do they change?* Draft Technical Brief 2 (July 3, 2008). Available at http://www.who.int/healthsystems/topics/delivery/technical_brief_ehp.pdf.

26. Frenk and Gómez-Dantés, "Ideas and ideals" (see note 2).

27. C. G. Victora and D. H. Peters, "Seguro Popular in Mexico: Is premature evaluation healthy?" *Lancet* 373/9673 (2009), pp. 1404–1405; G. King, E. Gakidou, K. Imai, et al., "Public policy for the poor? A randomized assessment of the Mexican universal health insurance programme," *Lancet* 373/9673 (2009), pp. 1447–1454.

28. World Health Organization, *Global health expenditure database.* Available at http://apps.who.int/nha/database; F. M. Knaul, E. González-Pier, O. Gómez-Dantés, et al., "The quest for universal health coverage: Achieving social protection for all in Mexico," *Lancet* 380/9849 (2012), pp. 1259–1279.

29. E. Gakidou, R. Lozano, E. González-Pier, et al., "Assessing the effect of the 2001–06 Mexican health reform: An interim report card," *Lancet* 368/9550 (2006), pp. 1920–1935; R. Lozano, P. Soliz, E. Gakidou, et al., "Benchmarking of performance of Mexican states with effective coverage," *Lancet* 368/9548 (2006), pp. 1729–1741.

30. F. Bustreo, P. Hunt, S. Gruskin, et al., *Women's and children's health: Evidence of impact of human rights* (Geneva: World Health Organization, 2013).