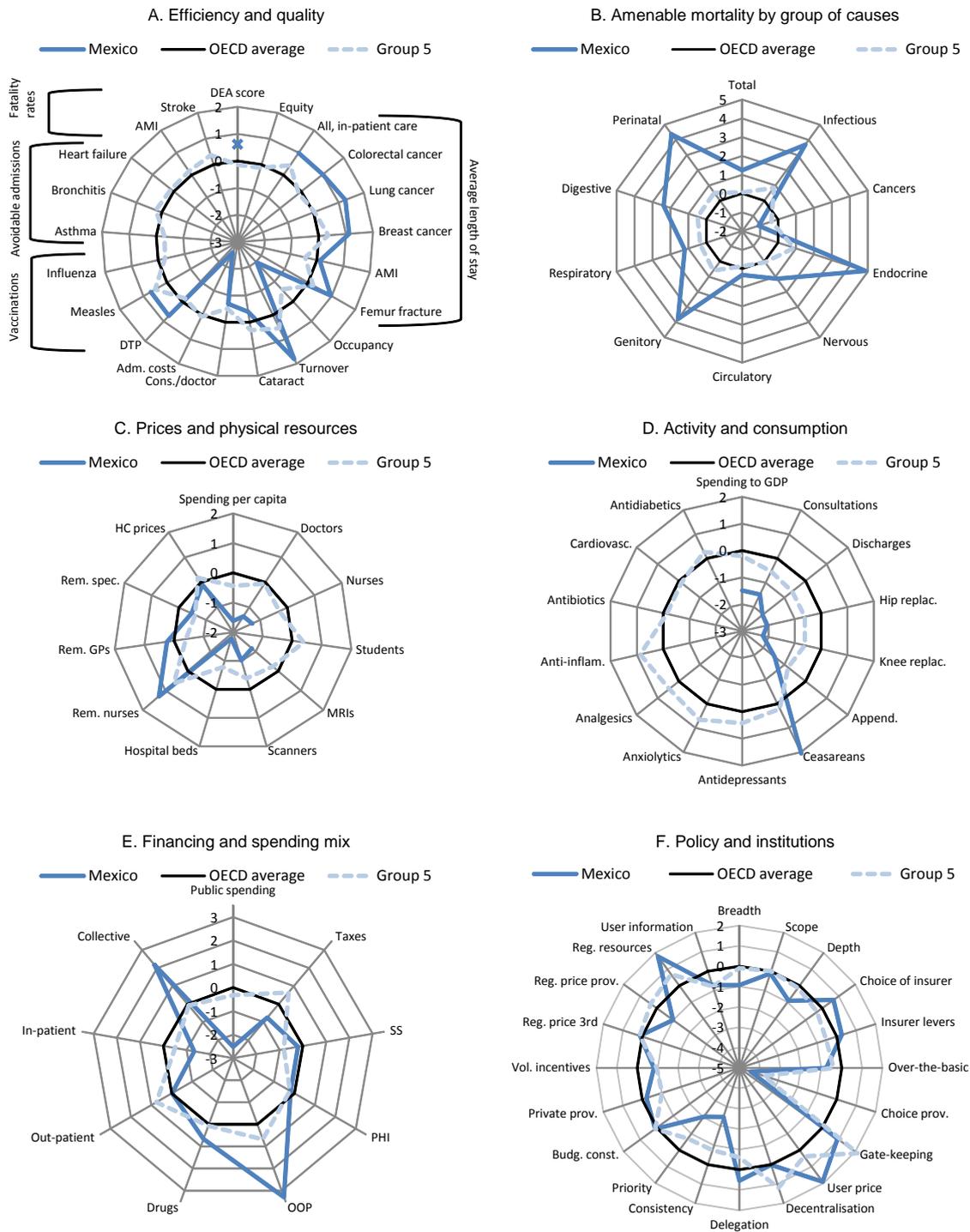


## Mexico: health care indicators

### Group 5: Denmark, Finland, Mexico, Portugal, Spain



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the average OECD country).

In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).

In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.

In Panel F, data shown are simple deviations from the OECD average.

Source: OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

## MEXICO

**GROUP 5:** Mostly public insurance. Health care is provided by a heavily regulated public system and the role of gate-keeping is important. Patient choice among providers is limited and the budget constraint imposed *via* the budget process is rather soft.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
High DEA score but amenable mortality remains high and information on inequalities in health status is lacking	Spending <i>per capita</i> and as a share of GDP remain low		Lower public spending share and higher out-of-pocket payments	Less breadth and depth of the basic insurance coverage, despite some choice among insurers given to citizens	Continued efforts to achieve universal health insurance coverage would help improving the health status of the population. Developing internationally comparable data on inequalities in health status and on the quality of care should be considered
High scores on output/hospital efficiency except a very low occupancy rate for acute care beds	Less nurses, high-tech equipment and acute care beds <i>per capita</i>	Less hospital discharges <i>per capita</i>	Lower in-patient share	More price signals on users but little choice across providers	Allowing insurers to contract with any provider would reinforce efficiency pressures on providers
Little internationally comparable data on the quality of care	Less doctors <i>per capita</i>	Less doctor consultations <i>per capita</i>	Higher drug share	Less regulation of provider prices	
Very high administrative costs	High relative income of salaried nurses and GPs			Less priority setting. Little decentralisation but some overlap in responsibilities across levels of government. Strict regulation of medical resources.	Explore ways to reduce administrative costs. Consolidating some insurance funds or establishing a unified claims management system could be options. Efforts to better set health care priorities and to improve consistency in responsibility assignment across levels of government should also be envisaged