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SHORT COMMUNICATION

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Overcoming the health systems' segmentation to achieve universal health coverage in Mexico

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Abstract

Health is a human right that everyone should be able to exercise. Yet health systems segmentation and fragmentation are a major challenge to advancing universal health coverage (UHC) and achieving health equity. Between 2019 and 2020, Mexico launched a profound restructuration of its health system claiming its aim was to attain UHC, free healthcare services and drugs and to combat corruption. We analyse the implications of the modifications of the Mexican Constitution and the dismantling of the *Seguro Popular de Salud* (Popular Health Insurance) in relation to segmentation. We argue that, instead of advancing towards UHC and equality, these changes reinforce inequalities and that transforming health systems must respect human rights.

KEYWORDS
health system segmentation, human rights, inequality, Mexico, universal health care

Highlights

- Starting in 2019, Mexico faces a profound restructuration inherently discriminatory of its health system
- The 2020 changes in the Mexican Constitution reinforce segmentation and discrimination
- These changes not only retard UHC but represent a step backwards
- Any effort to attain UHC should be based on total respect to human rights and with equity

1 | INTRODUCTION

Health is a human right that everyone should be able to exercise.[1] Exercising this right implies effective access to preventive, diagnostic, therapeutic, rehabilitation and palliative healthcare.[2] Yet, in low- and middle-income countries, health systems segmentation and fragmentation are a major challenge to advancing universal health coverage (UHC) and opening a way to achieve health equity.[3] Segmentation and fragmentation can compromise healthcare coverage and system efficiency, increase costs through service duplication, and result in diverse benefit packages to different population groups.[4,5] Most importantly for UHC, health system segmentation can drive inequities.[6] Low-income populations, with less political influence and ability to pay, often receive poorer quality services and more limited benefits packages, and can be exploited by private providers in unregulated markets.[7,8] Policy reforms play a fundamental role in health system financing, organisation, and governance,[9] with implications for health system segmentation.

Mexico's health system's major objective, as in any other, is to offer the best possible health level for its population contributing to the reduction of inequities.[10] Nevertheless, it hasn't yet reached the coverage -in terms of population, services and cost[11,12] that would guarantee access to health services for all.[13] Officially claiming to do so, between 2019 and 2020, the Mexican government launched a profound restructuration of its health system to combat corruption and offering all healthcare services and drugs for free and for all the population.[14]

This commentary analyzes the implications of these recent modifications introduced at the highest legal level, in relation to segmentation[15] and its relation with the stratified makeup of the country's social structure.

2 | ONE STEP FORWARD, AND TWO STEPS BACKWARDS

In his third annual address to the country, President Andrés Manuel López Obrador expressed his goal of building a universal health system based on equity and without any kind of discrimination. He declared:

> The dream I want to turn into reality is that at the end of my administration the health system will make it possible for any person, regardless of their economic, social or cultural condition, to receive the healthcare they deserve: with free doctors, specialists, exams and medication; and that health will definitely stop being a privilege and that it will become a universal right for our people.[16]

This aspiration is aimed at achieving the objectives of any health system.[10] But, instead of advancing towards them, the modifications introduced in November 2019 to the General Health Law and the National Health Institutes Law,[17] as well as those of May 2020 to Article Four of the Political Constitution of the Mexican United States, endorse and reinforce the segmentation of the Mexican health system.[18]

3 | THE STRUCTURAL SEGMENTATION OF THE MEXICAN HEALTH SYSTEM

In spite of the aspiration of justice and equality of the constitutional pacts of independent Mexico, a profound inequality still exists and even seems to be exacerbated among different social groups.[19] Inherited from both the colonial caste system with its racist-classist ideologies and the capitalist system that stratifies the population according to their relation to the property of the means of production, the Mexican society and State are founded on a hierarchical division of groups of people that has been normalised.[20]

Today, the Mexican health system still reproduces old colonial reminiscences that have been adapted to the needs of modern capitalism. Its construction and consolidation in the post-revolutionary governments of the twentieth century gave it its essentially segmented configuration.[15] Access to healthcare services is still based on corporativist

criteria essentially linked to the place each individual occupies in the labour market.[21] Stemming from a Bismarckian vision, on 1943 the social security institutions were progressively established for the sector of the population hired as wage labour.[22] First, the *Instituto Mexicano del Seguro Social* (*IMSS* – Mexican Social Security Institute) and then other institutions[a], established mechanisms that guaranteed access to healthcare services and other benefits influencing the social determinants of health. Simultaneously, the State has been responsible of the provision of healthcare for people without a wage labour position, usually the poorest, not as a citizenship right, but based on an assistance criterion influenced by the ideological priorities, the budget and organisational possibilities of each administration.

Currently, the Mexican health system includes a wide and heterogeneous private sector alongside with several public sub-sectors: five social security institutions (*IMSS*, *ISSSTE*, *PEMEX*, *SEDENA*, *MARINA*) and four organisms responsible for the provision of healthcare services to the population without social security: the *Secretaría de Salud* (SSa – Federal Ministry of Health), the ministries of health of each one of the 32 Mexican States, the *Instituto de Salud para el Bienestar* (*INSABI* – National Welfare Institute) and *IMSS-Bienestar* (originally *IMSS-COPLAMAR*), which was created in 1978 by the federal government to extend health coverage under the management of *IMSS* in extreme marginalisation regions.

The basic segmentation of the health system led to its fragmentation in several institutions with different financing criteria, operation rules and services packages that created duplicity, bureaucratic inefficiencies, inequities in access, healthcare quality and health results. This becomes clear when comparing the per capita financing of each institution, which shows ten-fold differences between *PEMEX*, *SEDENA* and *MARINA* on one side, and *IMSS-Bienestar* on the other (Figure 1). All this in a context where the public health expenditure of Mexico is among the lowest in Latin America (between 2.5% and 2.9% of GDP during the last decade) while out-of-pocket expenditure has consistently augmented since 2013, representing 42.1% of overall health spending in 2019.[23]

4 | HISTORICAL EFFORTS TOWARDS A UNIVERSAL HEALTH SYSTEM

During the past 40 years continual, though insufficient, efforts have been made to solve segmentation and to build a universal health system.[24] A landmark was the definition of the right to health protection in Article Four of the Mexican Constitution in 1983,[25] which implied two main things:

1. The recognition of health protection as a right and no longer as a prerogative or reward.

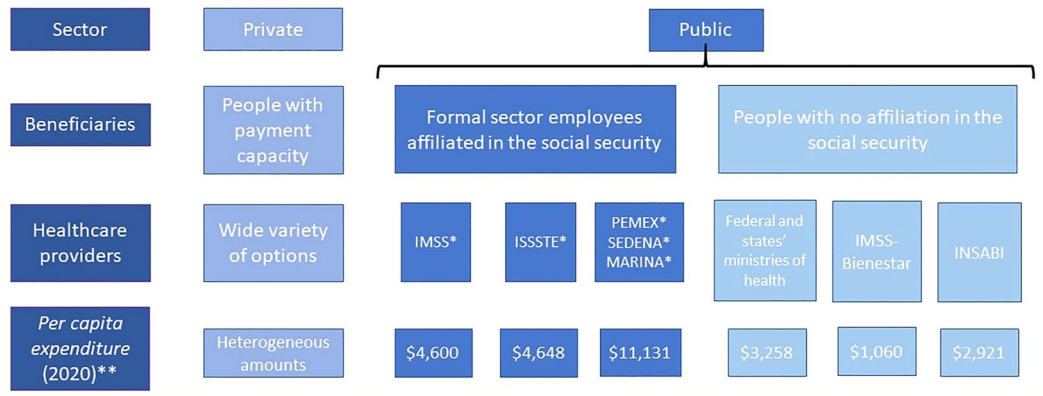

FIGURE 1 Institutional structure and per capita expenditures in the Mexican health system

2. The establishment of citizenship as the main criterion to exercise this right not related to the labour, social, economic or union status.

Abandoning assistance or charitable connotations far removed from citizens' rights, the *Secretaría de Salud y Asistencia* (Secretary of Health and Assistance) changed its name to Secretaría de Salud (*SSa*). Simultaneously, a progressive decentralisation process transferred responsibilities to the states aiming to give a more efficient response to the needs of local populations.[25]

In 2003, the *Sistema de Protección Social en Salud* (*SPSS* – Social Health Protection System) was created to solve existing imbalances and to strengthen the SSa's stewardship.[26] This reform established a public medical insurance -*Seguro Popular de Salud* (Popular Health Insurance) - for all citizens excluded from the different social security schemes, with a public and solidarity insurance scheme similar to that of the social security. This reform represented an intermediate step towards the construction of a universal health system that started with the integration of its functions: stewardship in the hands of the *SSa*, unified financing and plural provision of healthcare facilitating free choice of health provider and creating quality and efficiency incentives. The 2006 *Estrategia para la Portabilidad y Convergencia* (Portability and Convergence Strategy) was bound to promote coordination of healthcare provision among institutions and reduce the drawbacks of fragmentation.[15,27] At the end of 2018, with more than 81% of the population covered by a public medical insurance,[28] Mexico had the opportunity to deepen the articulation of a single financing fund including the social security institutions and SPSS, and offering medical care for all citizens in any public health institution, regardless of their labour status.

5 | REINFORCING THE HEALTH SYSTEM's SEGMENTATION

The November 2019 amendments to the General Health Law repealed the *SPSS* and its financial structure, substituting them with the *INSABI*.[17] Its declared objective is to provide and guarantee the free provision of health services, drugs and other health inputs to the population that has no social security, recognising their right to health and the State's responsibility to guarantee it.

Yet, on 8 May 2020, the *Diario Oficial de la Federación* (Official Journal of the Federation) published a modification of Article Four of the Mexican Constitution that, instead of facing the structural roots of inequality, legitimates them giving a legal basis to the segmentation of the health system.[18] The fourth paragraph of Article four is now formulated as follows:

> Every person has the right to health protection. The law will define the basis and modalities of access to health services and will establish the concurrence of the Federation and the states in matters of general health, according to what is stated in fraction XVI of article 73 of this Constitution. The law will define a system of health for welfare in order to guarantee the progressive extension, in quantity and quality, of healthcare services for the integral and free care of the people that do not have social security.[18]

This change in the Constitution and the creation of *INSABI*, as well as the more recent designation of *IMSS-Bienestar* as main healthcare provider for those who are not social security beneficiaries, perpetuate the health system's segmentation and corporatism by establishing a parallel health system responsible for people without social security. The norm that defines the social pact of Mexico apparently justifies the existence of two citizenship categories concerning health. One for those who are employed in the formal sector and enjoy the rights to social security. And a *second-class citizenship* for those who, not having this kind of employment are not entitled to the social security and, thus, are the object of assistance healthcare services that can easily adopt the form of a gift from the government. This modification reinforces the legal ground for the old stratification and strengthens the State corporatism.[29]

The inequality derived from the existence of people that benefit from their participation in the formal economy versus those who make a living away from any employer-employee formal relationship further deepens inequity (an unjust and avoidable inequality) in access to healthcare services. From a human rights perspective, the consequences of these changes can be disastrous, they bolster segmentation and foster the creation of clientelist groups.

Furthermore, these modifications even contradict the basic ideas of Article one of the Constitution, which states:

> All discrimination based on ethnic or national origin, gender, age, handicaps, social conditions, health conditions, religion, opinions, sexual preferences, civil state or any other that violates human dignity and has the purpose of nullifying or impairing human rights and liberties of people is forbidden.[30]

The Constitution should by no means validate the segmentation of the population for the exercise of their rights. Instead, it must ensure the legal equality of citizens. It must oblige the State to end this differentiation defining citizenship as the only condition to guarantee access to healthcare services, opening the way for a social response addressing the health needs regardless of labour status. Nevertheless, the new formulation of Article four, far from promoting the democratisation of the right to health protection, favours the establishment of passive clientelism.

6 | RETHINKING ALTERNATIVES FOR THE MEXICAN HEALTH SYSTEM

We propose two principles to analyse the implications and correct the effects of the above-mentioned modifications.

1. Article one aspiration to ensure the largest protection to all people.
2. Equality before the law for all citizens, based on the recognition of the essential value of all human life.

Laws must promote strict respect to human rights and avoid any formulation that conceptualises and justifies inequalities as permanent traits of the social structure, and even in a veiled manner, set the basis for paternalistic assistance policies. A publicly financed universal health system can be the basis for the construction of a larger Universal Social Security scheme including benefits such as retirement pension, disability, and death insurance, among other benefits. This must be a long-term project with a state vision for the next decades, starting with the most vulnerable populations and those who have historically suffered the consequences of inequality, particularly the indigenous people.[31]

Correcting the segmentation of the health system is not an easy task; it will require innovative public health policies, resources, time and effort. It implies also affecting political and economic interests of powerful groups: the social security institutions, their workers, and their unions.[32,33] We have no available incentives for them to be willing to abandon their privileges. It is necessary to create political consensus and to build a medium- and long-term state vision. The academic community has a relevant role in building this consensus, particularly health systems specialists. They must provide a technical support and sound robust evidence for discussion. A most important scene for debate is the legislative power and a first urgent measure is to revert the changes to Article four and the legal support for segmentation. A second step may be separate financing from healthcare provision; proposing convergence mechanisms among the funds of all concerned institutions to create a unified health fund and the conditions to guarantee the provision of healthcare services for all citizens in any public health institution.[34] A third measure is to define an explicit and gradually growing package of services for all citizens based on technical criteria as well as its financing mechanisms.[31] In addition, given Mexico's ethnic and cultural diversity, it is essential to consider measures to address non-financial barriers to access to health services, not only those related to physical accessibility, autonomy or knowledge, but especially those represented by forms of discrimination and exclusion of indigenous peoples, Afro-descendants and impoverished populations.[35]

7 | LESSONS FOR HEALTH SYSTEMS

The recent transformation of the Mexican health system offers lessons for other health systems in the world. First, we highlight the need to recognise all legal and institutional heritage building on its progress and achievements. It is essential to avoid general, and basically ideological, disqualifications of what has been done by preceding administrations. Institutional destruction inevitably generates the aggravation of health lags and inequities.

The COVID-19 pandemic exacerbated inequities demonstrating that people who live in structural vulnerability conditions are the most unprotected against health risks, among them, those who have no health insurance.[36] In these circumstances, all decisions bound to reform the health system must consider the prevailing conditions of social injustice and favour the universality of health services that goes beyond an assistance clientelist vision.

Any transformation of the health system must be founded on the definition of its main objectives: health protection, financial protection, and dignified treatment – respecting the principles of human rights, especially the principle of equality of persons. Different routes can be designed to reach these objectives, but no answer should deviate from these objectives, and nothing can justify any kind of discrimination.

The technical competences of health sector officials must be privileged above ideological voluntarism. It is recommendable that any health system reform be based on a debate that includes the participation of specialists as well as that of the population so decision-making may be properly informed by scientific evidence.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

AUTHOR CONTRIBUTIONS

Sergio Meneses Navarro and Blanca Estela Pelcastre-Villafuerte conceived the main idea of the paper and designed the study. Sergio Meneses Navarro, Blanca Estela Pelcastre-Villafuerte and Victor Becerril-Montekio wrote the first draft of the manuscript. Victor Becerril-Montekio and Edson Serván-Mori provided critical input on multiple iterations. All authors were involved in revising the paper and approved the final manuscript. Blanca Estela Pelcastre-Villafuerte is the guarantor of this work.

ETHICS STATEMENT

Not applicable.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in PubMed at https://pubmed.ncbi.nlm.nih.gov/.

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ENDNOTES

[a] The *Instituto Mexicano del Seguro Social* (IMSS), the *Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado* (ISSSTE State Workers Security ad Social Services Institute), the medical insurance for the employees of *Petroleos Mexicanos* (PEMEX – Mexican Oil Company) the army and the marine (SEDENA, MARINA).

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