EDITORIAL

Is there a way forward for the Mexican healthcare system? A human rights perspective

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Abstract

Morbidity and mortality profiles offer us a synthesis of the dynamics of population health. Workplace conditions, education, nutrition, housing, income, access to potable water, adequate sanitary services, clean environments, and healthcare are all considered as social determinants of health. As such, they provide the necessary elements to guarantee the right to health and health protection. Mexico's adoption of neoliberal policies – in place now for three decades – has weakened the possibilities of leading a full life by converting health into a commodity and dismantling the public healthcare system. In its place, a market for medical services has been established and sick people are now blamed for having adopted unhealthy lifestyles. Surely, this is a very miserly realization of the right to health.

The Mexican healthcare system provides neither universal coverage nor universal access to health-care. The quality of services – when available – is quite variable. What is needed is a single, unified, publicly financed healthcare system; international experience has shown that this is the most efficient way to obtain universal coverage that provides comprehensive, quality care and equity. Achieving this in Mexico requires fundamental reform of both the healthcare and social security systems.

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The health situation in Mexico

Healthy communities are the product of the living and working conditions within which people carry on their daily lives. This depends, in turn, on the ability of societies to address – in quality and quantity – the essential human needs of its members.

The morbidity and mortality profiles of different populations reflect these conditions and are closely linked to such health determinants as employment, income, education, nutrition, housing quality, access to potable water, sanitary infra-structure, environmental health, and access to healthcare services. These are considered as the necessary elements to guarantee the right to health.[*]

Over the past 30 years, Mexico has experienced economic, social, and political changes that have led to an increasingly urbanized society integrated into the global economy as a subordinate power. Lifestyles have been transformed, as have work processes, the use of time, family arrangements, the pace of everyday life, and power relations within domestic groups.

Under the domination of neoclassical economics and neoliberal ideology, income has become concentrated among the wealthy, work has become both more flexible and less secure, unemployment and under-employment have increased, public goods have been privatized, and oligopolistic markets are favored by deregulation. "Quality time" is reduced while citizens live under conditions of permanent stress. Socialization assumes new forms that disrupt

[*] According to the OAS, the right to health is an inclusive right that involves not just appropriate and timely healthcare, but also engagement with the principal determinants of health status. (OAS, 1988)

Table: Mortality Indicators. Mexico 1980-2015

Indicator	1980	1990	2000	2005	2010	2014
Life expectancy at birth (years)	67.0	71.4	74.0	75.7	74.3	74.9
Infant Mortality		32.6	20.9	22.9	14.1	10.7
Child mortality (Ages 0-4 years)*	54	36	28	20	19	12
Mortality, adult males (15-59 yrs)*	246	186	158	139	122	not available
Mortality, adult women (15-59 yrs)*	145	107	91	79	66	not available
Mortality, all causes*	6.7	5.0	4.5	4.8	4.2	5.2
Mortality attributable to communicable diseases, nutrition, and reproductive causes**	34.4	26.2	14.0	14.0	12.5	12
Mortality, noncommunicable diseases**	49.8	59.8	73.3	73	73	75
Mortality, accidental and intentional injuries**	15.7	13.9	12.7	13	12.5	13

* Per thousand population, estimations are based on mortality tables. ** Per hundred. **Sources:** National Health Program, 2001-2006, Mexico; National Health Program, 2007-2012, Mexico and National Health Program, 2013-2018, Mexico; National Health Information System (SINAIS) (2008) Life expectancy by State. Accessed March 13, 2015. Available at: http://goo.gl/lUUAxW; EspVidaNacer2000-2007.xls, National Population Council (CONAPO) (2014); Population Projections in Mexico 2010-2050: http://bit.do/IndicadoresDemograficosMexico. Accessed March 13, 2015; Infant Mortality Data: Mortality and life expectancy in 2015 http://goo.gl/jNFM8b

the existing social norms and lead to an increasingly frayed social fabric associated with multiple forms of violence.[1]

These transformations in lifestyle and demographics have occurred in a context of widespread impoverishment and increasing inequalities. Collective health is faced with an epidemiologic picture characterized both by nutritional deficiency syndromes and infectious diseases, as well as the morbidity associated with non-communicable diseases, such as premature death and disability in adults. In addition, we continue to see increases in both accidental and intentional injuries.

The neoliberal model ravaged the economy, marginalizing the majority of Mexicans. Wealth is now concentrated in the hands of the few. This pro-market agenda is the handwork of a State which has been coopted by interests who act behind the scenes and without any accountability. The State has completely disregarded its constitutional responsibility to protect human rights. The increasing threats to health are manifested in increasingly complex epidemiological profiles, the challenges faced by those who are disabled, and in the persistence of socio-sanitary inequities.

In 2010, the leading causes of death in women included ischemic heart disease, diabetes mellitus, chronic kidney disease, and cerebrovascular disease; in men, the leading causes of death included ischemic heart disease, cirrhosis, diabetes mellitus, chronic renal disease, and homicide. (see Table)

Socio-sanitary inequalities

Poverty

Social polarization in Mexico has resulted from the impoverishment of the population with a resultant growth in inequalities. Between 2010 and 2012 poverty in Mexico grew from 52.8 to 53.3 million people, out of a total population of 117 million. According to a report on the measurement of poverty prepared by the National Council for Evaluation of Social Development Policy, some 45.5 percent of Mexicans are poor and 40.7 million more (34.7 percent) are at risk of falling into poverty, either because of low incomes and/or lack of access to education, health, housing and social security.[2] This means that 8 out of 10 Mexicans are either poor at or risk for becoming poor. The report noted that extreme poverty had decreased 1.5 percent between 2010 and 2012. Despite this decline, some 11.5 million Mexicans still live in extreme poverty.[3]

Gender Inequalities

Gender inequalities are also striking. There are 2.5 times more women living in poverty than men living in poverty. 8 million women work and still have neither health insurance nor the right to obtain health insurance. Fully 7.5% of women over 15 are illiterate, as compared with only 4.8% of men over 15.

Indigenous Communities & Urban/Rural Disparities

Indigenous communities tend to concentrate the most acute conditions of poverty and marginalization, as indicated by very unfavorable indices of human development. For instance, 32.5% of the indigenous population over 15 years is illiterate; in some communities the illiteracy rates for women are twice that of men.

These conditions of poverty and inequality are manifested in epidemiologic profiles that are increasingly polarized and complex. Data from various sources including the Ministry of Health and PAHO[4] suggest that in 2011 life expectancy at birth was 73.2 years for males and 77.9 years for females. In the indigenous population, life expectancy was only 68.6 years.[5] Similarly, the prevalence of short stature is far more common in rural than in urban zones. Both malnutrition and hunger are found in the countryside.[6]

In 2010 infant mortality in Mexico City and Nuevo Leon was relatively low: 10 deaths per thousand births. The rural states of Chiapas, Guerrero, and Oxaca reported infant mortality rates of (respectively): 18.9, 19.1 and 17.1.[7] Similar disparities can be observed in towns with lower Human Development Index (HDI) scores. In these places infant mortality can reach rates of 32.5 deaths per 1000 births. While progress has been made, towns with lower HDI report infant mortality rates twice the national average.[8]

Data also suggests that almost a third of all deaths in the 100 most marginalized municipalities are due to communicable diseases, nutritional deficiencies, and reproductive problems. These values are similar to those seen 18 years ago in the capital and 25 years ago in Nuevo Leon. Women living in the poorest towns have a life expectancy of only 51 years; men only 49 years.[9]

Maternal Mortality

Similar differences are seen when we look at maternal mortality. For Mexico as a whole the maternal mortality rate (per 100,000 live births) is 51.5, a relatively high number. In the rural states of Guerrero and Oaxaca maternal deaths are reported to be 85.5 and 88.7 respectively.[10]

Psychological Illness and Substance Abuse

Psychological and substance problems are becoming increasingly prevalent. The National Psychiatric Survey found that 7.8% of the population had experienced a major depression. The ratio of females/males reporting major depression was 2.5:1.[11] Cigarettes remain responsible for approximately 60,000 deaths annually and 14 million Mexicans between the ages of 12 and 65 still smoke. In 2012, 68% of Mexican men used alcohol, up from 56% in 2000. Respective figures for women are 24% (2000) and 41% (2012). It is thought that alcohol is a factor in 50% of auto accidents which involve a fatality.[12] This represents an additional 24,000 deaths a year. These accidents generally involve young drivers, who represent 34% of traffic fatalities.

The National Substance Abuse survey reported that among Mexicans between 12 and 65 years of age, drug consumption had increased from 5% in 2002 to 5.7% in 2008. Drug consumption rates in cities are twice those of rural areas.[13]

Among the key risk factors for women between 15 and 24 years of age are drug consumption and domestic violence. For men in this age group the principal risk factors are alcohol consumption and occupational injuries.[14]

Occupational & Environmental Health

Surveys tend to underestimate the rate of work-related illness and injury as well as the health impact of environmental contamination. The government currently collects data only on those work-related illneses that are specifically recognized in Mexican legislation. In addition, companies typically under-report accidents in order to keep their insurance rates low. Environmental contamination (either at home or in the workplace) is often an invisible or overlooked health threat. It can be due to the massive use of pesticides in agroindustry, to extractive industries (e.g. open pit mining), or to urban environments characterized by air pollution from cars and factories. Current data does not allow us to have an accurate picture of what is happening nationally.

Violence

Violence has also increased in the past several years; this is typically (but not exclusively) an issue involving young men. Mortality in men due to homicide was 35.6 per 100,000 men with a ratio of male to female deaths of 8.3:1.[15] The death rate is so high that it has caused a decline in life expectancy of 0.6 years.[16]

Every day violence is responsible for 50 deaths, 1250 medical visits, and 100 new cases of disability. Murders related to drug traffic have increased dramatically; in 2009, Mexico was estimated to have spent 8.9% of its GDP on security.[17]

International Comparisons

The social and sanitary indices we have discussed paint a complex and uneven picture of Mexico's current health status. We can compare them to similar indices in Cuba or Canada or with the average values in the OECD. These comparisons would show important deficits in terms of Mexican life expectancy, neonatal mortality, infant mortality, maternal mortality, deaths due to cervical cancer, diabetes, and car accidents.[18] We can also point out that not even the goals that Mexico had committed to attain as part of the Millennium Development Goals (MDG) will not be met. There have been notable failures with respect to maternal mortality and HIV/AIDS.

Mexican Healthcare

The Mexican healthcare system has traditionally been divided into three subsystems which serve very different clienteles. 1) The Social Security system provided care to the employees of the Mexican Social Security Institute (IMSS) and the Institute providing social security and social services to Federal employees (ISSSTE), state employees, employees of the Mexican Oil Company (Petroleos Mexicanos), and to the Departments of Defense and the Navy. 2) The "open" system – a public system – which was run by the Ministry of Health and was divided into 32 state health programs, the IMSS Prospera program and the DIF program (Desarrollo Integral de la Familia); and 3) The private system which is quite diverse, ranging from small and medium sized clinics all the way up to large hospitals. Health services were often provided by pharmacies, churchs, and a variety of smaller organizations. Not only is the private sector organizationally diverse, it is also quite heterogenous in terms of quality, financing, services offered, goals and population served.

Fragmentation

The break up of the National Health System has resulted in a multiplicity of new programs. In 2010 the Federal Government (Mexico City) alone had 40 different programs and initiatives related to health services and access to them. These programs represented 64% of the resources set aside for health and social development, some 227,646,000 pesos. This represented 15% of the 273 social development programs indexed in CONEVAL 2010.

This degree of organizational division creates barriers to efficient and high-quality management. It has kept the National Health System from becoming an efficient and effective tool and from expanding its coverage. In a fragmented organization it is difficult to provide accessible, acceptable, high quality healthcare services and to maintain equitable standards for all patients. National Health System's ability to respond to the complex health problems in Mexico has been compromised.

Until 1982 the main social security institutions (IMSS and ISSSTE) had been able to provide medical attention to the general population despite the fragmentation of the healthcare system. They developed a heterogeneous network of services across the country and steadily increased coverage, gradually incorporating new populations into the system. But this progress did not survive the period of structural adjustment and the demands made by the neoliberal agenda on a subordinate state. Successive governments have sought to dismantle these public institutions and replace them with "packets" of "basic services" designed for the poor. At the same time the development of private services for the well-off has been fostered.[19]

The end result is spiral in which public funds are cut, the public system underfunded, services deteriorate over time, equipment becomes obsolete and is not replaced, and gradually there are either not enough public facilites or the existing facilites are clearly substandard. The deterioration of the physical structure is accompanied by a series of measures to undermine working conditions for the staff. All this is "explained" by a technocratic discourse which ignores the social production of disease and makes the patient responsible for his or her risk behaviors and unhealthy life styles.[20]

This process is best illustrated by examining public health expenditures in Mexico from 1982 to 2004, a period during which public spending on health decreased from 3.7% of GDP to 2.7%.[21] After 2004 there was some improvement, due primarily to money spent on the Seguro Popular system and health expenditures reached 3.1% of GDP in 2012; this remains significantly below 1982 healthcare financing levels. IMSS has suffered the most from these cuts, and its sickness and maternity care funds have been particularly hard hit. A 1997 "reform" privatized IMSS's pension funds and forced IMSS to create new economic reserves. This made it more difficult for IMSS to move funds around to address areas that needed extra funding. It has also limited IMSS's ability to invest in new medical infrastructure; needed upgrades are thought to require 60 billion pesos.

Existing infrastructure is woefully inadequate. While in 1982 IMSS provided 1.2 offices for every 1000 covered patients, this number had dropped to 0.4 in 2006. Similarly the number of hospital beds per 1000 covered patients dropped from 1.7 per 100,000 in 1982 to 0.83 in 2006.[22] Current statistics show that per 1000 covered lives, IMSS has 0.45 physicians and 2.5 nurses. OECD averages for these categories are 0.8 physicians and 9.6 nurses. Clearly, IMSS has a human resources problem.[23]

The situation is worse at the state level where we see marked regional differences in terms of financing, access, and service quality. Public spending on health varies widely from state to state. Mexico State, Michoacan, Puebla, and Chiapas all spend between $1250 and $1500 pesos per person per year; Campeche, Tabasco, and Baja California spend on average $3,500 pesos per patient, and Mexico City spends $6,000 pesos.[24]

Poor families saw their medical bills practically double between 2000 and 2005 going from 8% of income to 14%. In wealthy households medical expenses remained at 4% of income.[25]

There are also important inequalities with respect to availability of resources. In the states of Chiapas, Oaxaca, Puebla, Michoacan, and Zacatecas there are 0.4 to 0.8 physicians for every 1000 inhabitants[24]; in Colinas, Agascalientes, Baja California Sur, and Mexico City there are 1.6- 2.7 physicians for every 1000 inhabitants. In the states of Aguascalientes, Colima, and Mexico City all births are attended to by trained personnel; in the states of Mexico, Guerrero, and Chiapas this is case for only 50% of births.[26]

Three decades of neoliberalism have deteriorated the social determinants of health and led to what might be called "a socio-sanitary paradox": health problems have increased and grown more complex while the ability of the government to address these problems has been reduced. The institutions which historically dealt with health have been destroyed. The result is that for many Mexicans the right to health has become nothing more than a mirage.[27]

This paradox, the result of political decisions and neoliberal reforms, goes beyond simply the physical infrastructure of the healthcare system and its management.[28] It impacts the symbolic meanings associated with health, disease, and death. It promotes the idea of a "neutral" healthcare system guided by technocratic "solutions." Its emphasis on efficiency damages and discredits the very idea of a universal, public healthcare system.[29]

Access to healthcare services

The current National Health System fails to provide universal coverage. Benefits, and their quality, vary widely from state to state. Rural areas in particular are face difficulties in accessing the system. Nearly 31% of rural communities containing 1,500 to 2,500 inhabitants lack a local health center.[30]

In 2010 34% of the population (38 million people) reported difficulties accessing the system. In 420 municipalities (17% of the total number) more than half of the inhabitants reported a lack of health services. In only 32% of the municipalities do less than a quarter of the population report access issues.[31]

Seguro Popular & its failures

The most recent attempt to address these problems and increase healthcare coverage was the Sistema de Proteccion Social en Salud (Social System to Protect Health) whose operational arm is Seguro Popular de Salud (Popular Health Insurance) which began operations in 2004.

The Sistema de Protección Social en Salud was created in May 2003 through an amendment to the General Health Law (LGS). The goal was to provide clinical services, medications, and hospital services to groups that were not covered by the social security system. Seguro Popular was designed in accordance with macroeconomic principles. Rather

than addressing the serious problems affecting the healthcare sector, it continued the existing policy of reducing the healthcare system and limiting Mexican's constitutional right to health protection.[32]

Currently Seguro Popular covers 285 interventions for 1,534 specific diagnoses. This represents a gradual expansion of services; there has also been an addition of several supplementary programs including a "21st Century Medical Insurance Program" that was introduced for children less than five years old. President Enrique Peña Nieto added a health component into the Programa de Desarrollo Humano Oportunidades (currently known as PROSPERA). In addition to providing healthcare services, this program incorporates some health promotion, such as nutritional supplements for children from 6 months of age until 59 months and for pregnant or lactating mothers.[33]

As part of its Catastrophic Expenses Fund (Fondo de Protección contra Gastos Catastróficos) 59 highly specialized (tertiary care) interventions for 19 diseases are also covered. Finally some diseases not covered in CAUSES or the Catastrophic Expenses Fund are still covered by the 21st Century Medical Insurance Program.[34]

Although Seguro Popular has increased the number of covered services, it still follows a neoliberal agenda by fostering the private medical system and assuring that public funds continue to support the healthcare market. The program also maintains a complex and burdensome administrative and financial structure that models public services on the dynamics of private insurance.

Despite increases in Seguro Popular's budget between 2004 and 2011, there was no significant decrease in out of pocket spending for members of the plan. This means one of the central goals of the program – protecting the poor from medical expenses – was not accomplished despite increased funding.[35]

Seguro Popular was implemented without the proper infrastructure and its employees continue to work in substandard conditions. As steady employment in Mexico is increasingly replaced by informal work, there has been a huge increase in the number of people who are no longer covered by the Social Security system. For these informal workers Seguro Popular is their only option. Yet Seguro Popular does not have the resources to provide quality care to this new population.

For the period of January to June 1913, Seguro Popular was reported to cover 53.3 million people. Coverage, however, does not guarantee effective access to services.[36] In reality, access depends upon a number of factors including availability of services, physical location, and cultural acceptability. Effective access implies that services are available, and that when they are available, they are offered in a nondiscriminatory manner, at the appropriate technical level, and with respect to the patient's dignity.[37]

No data exist documenting the impact of Seguro Popular on population health. However, the Encuesta Nacional de Afiliados al Seguro Popular (National Survey of Seguro Popular Enrollees) makes it clear that the program is not reaching populations that have been historically excluded from medical care.[38]

In summary, the "global heathcare market" supported by Seguro Popular has failed on a variety of measures. Recent official attempts to revitalize Seguro Popular as a platform for Universal Health Coverage simply repeat the mistakes of prior privatization efforts and serve only to further weaken the Social Security system.[39]

Actors and a disputed agenda

Various actors have pushed the neoliberal agenda in Mexico since the 1980's. They have been successful in reconfiguring the healthcare and the social security systems by privatizing the profitable parts of the public sector and using public funds to support universal healthcare in a private market.[40] The common goals of these reforms have been to foster a private healthcare market, promote mixed public/private solutions, gain access to public funding, and promote competition for "clients."

The major actors in this process have been large, international organizations such as the World Bank, the IMF, and the InterAmerican Development Bank (IDB), all of which have promoted privatization of the public system.[41] Locally, the Mexican Health Foundation (Fundación Mexicana para la Salud, FUNSALUD) has been an active supporter of privatization[42] along with the Mexican Association of Insurance Companies (Asociación Mexicana de Instituciones de Seguros, AMIS),[43] the Business Coordinating Council (Consejo Coordinador Empresarial),[44] the Carlos Slim Health Institute (Instituto Carlos Slim de la Salud)[45] and the group associated with Santiago Levy.[46] These

organizations have been able to forge a coalition that has been a hegemonic force in healthcare management and has developed the key proposals for "universal" healthcare coverage.

The neoliberal agenda has been opposed[47] by a diverse variety of groups: academics, civil society organizations, democratic unions, healthcare workers, and users groups. The actions of these groups have been largely uncoordinated and have not been able to halt the advance of the various "reforms." The opposition has tried to defend specific aspects of the old system: the right to health, universal, publicly-funded programs, a strong primary care base, quality, accessible healthcare services, non-discrimination, gender sensitivity, inclusivity, and coordination of the system with other sectors in order to improve the social determinants of health.

Towards a Single Unified System (SUS)

The right to health has been established in international agreements to which Mexico is a signatory. Making this right a reality will require reforming the current system and promoting intersectoral work on the social determinants of health.

The right to health is an inclusive one. It incorporates two dimensions: the social determinants of health and systems created to protect health and provide care to individuals who are ill. Action on social determinants involves structural issues such as the guarantee of other rights (economic, social, cultural, and environmental) as well as placing health at the center of all policies.[48, 49] Social Security must be established as a human right for all Mexicans.[50] This runs against neoliberal thinking which sees Social Security as a privilege available only to the formally employed working class or those who are well off.

The second dimension refers to the health system and health sector policies. The state is obliged to protect, promote, and fulfill the right to health by providing political, legal, regulatory, and programmatic guidance throughout the various levels of the public system.

In the current context of a severely fragmented system, the first step towards creating a Single Unified System (SUS) needs to be the harmonization of institutional norms and programs. The provision of healthcare services needs to be standardized across the various subsystems. Given its institutional capacties, the health programs of IMSS should serve as the reference standard in this process and offer a platform for incorporating the other social security system's healthcare facilities.[51] IMSS is present throughout Mexico and has the administrative capacity to integrate the other programs. Further, current legislation allows IMSS to incorporate additional groups. This would permit IMSS to become a single system providing healthcare services in agreement with Article 4 of the Mexican constitution[52] as well as the various health-related treaties and agreements that Mexico has signed.

A Single Unifed System is the key to providing healthcare to all Mexicans because it is based on the idea that health is a social right and not simply an individual guarantee.The right to health is the basis for providing services regardless of insurance status or geographical location; there are no restrictions. The right to health needs to put into law and the appropriate organizational and administrative measures taken to make sure that all Mexicans are guaranteed unlimited access to healthcare except in special cases that are specifically written into the law.

The creation of Single Unifed System will face significant challenges, some of which have been mentioned previously. The most important among them are the institutional and programmatic fragmentation of the existing system(s), the multiple financing streams, the various forms of user fees, the overlapping needs of users, the financial crisis facing the Social Security system, inequities in service provision, and the variable quality of medical care.

The unification of existing systems needs to take place within a healthcare model that is based on primary health care and addresses the social determinants of health. This requires creating comprehensive service networks at the regional level which incorporate health promotion, as well as disease prevention and care. These services should address the needs of individuals and communities in accordance with the complexity of their health problems.

This model requires a human resources policy that trains staff that can respond adequately to complex cases, support the reform of primary care and contribute to the education and distribution of future healthcare pofessionals.

The Single Unifed System would be run by the Ministry of Health. Its function would be to provide appropriate medical services to individuals, as well as to particular age and social groups. Care can be provided on an individual basis or to groups. Interventions can involve personal care and/or sanitary measures addressing public health. The Ministry would establish policies and strategies to guide these interventions. Personal care would be based on the WHO diagnostic codes promulgated in ICD-9 and ICD-10. Certain items would be legally excluded (such as cosmetic surgery).

A System of Comprehensive Health Care Services (SIAM) should be adopted throughout the Single Unifed System. Organizational changes will be required so that patients can access services without discrimination based on employment status, gender, ethnicity, economic or political ideology, sexual orientation, or any other personal attribute.

The Single Unifed System will be based on public health units which address varying levels of complexity. Care will be based on the needs of local populations and will be organized both geographically (into regions) and stratified based on the complexity of the problem. All citizens will have access to the appropriate level of care; when clinically appropriate, patients will be transported to facilities where more advanced care can be provided. Regardless of their current institutional affiliation, all healthcare facilities will be managed as public institutions and will subject to existing public norms.

The Single Unifed System will be based on a revitalized primary care system. Primary care units will usually be the place ambulatory patients present for care. From the primary care unit, referrals can be made to more advanced units. Within the SUS, primary care will be provided in health centers, family medicine units, and family clinics staffed by Famly Medicine doctors who can provide specialty-level services within their own offices. Secondary care would be provided in institutions staffed by medical and surgical specialists. These include: ambulatory centers, specialty referral centers, ambulatory surgical centers, emergency rooms and short term evaluation and treatment centers. These centers would be equipped with the capacity for sophisticated diagnostic and treatment procedures.

Tertiary care includes specialized medical or surgical units, national or regional hospitals qualified to handle low or moderately complex cases. They will generally have highly sophisticated technology used only in very specific cases. Some institutions will offer subspecialty care, often for patients who have had prolonged hospitalizations and require simultaneous interventions from several specialist teams.

Initially, all healthcare personnel including healthcare professionals, support staff and administrative staff will retain their current professional affiliation. Overtime, they will be absorbed into the SUS and be either considered government employees or independent contractors, depending on the agreement reached between the SUS and the worker.

Those needing to access the SUS will only need a legal document confirming their identity. This will be stored in the SUS Unified Register (RUAM, Registro Único de Atención Médica). A medical record would be established and assess confirmed. These processes will be done in conformity with the confidentiality rules of the Federal Institute of Information Access (IFAI, Instituto Federal de Acceso a la Información).

There will be no restrictions on services offered by the SUS. Services will be provided in function of their medical appropriateness and guidelines which will take into account the diagnostic methods, therapeutic measures, and material resources needed to provide comprehensive, high-quality medical and/or surgical services. Each level of the SUS will be resourced to provide the appropriate services for its level of complexity

The system will be funded via a general fund for health created through tax revenues and employer contributions within the social security system.. We estimate that the Fund will need an initial $ 5762.00 pesos per person based on 2015 figures (US $ 335) It will supply resources to the various sectors of the health and social security system in accordance with the number of patients seen, the final diagnoses, and the clinical outcomes. Quality would be evaluated with measures such as the most common causes of morbidity and mortality, hospital-related deaths, and higher than average use of diagnostic and therapeutic resources. An ad hoc committee would be charged with evaluating such measures.

The global budget and its distribution will be based on a capitated amount for each inhabitant (based on census data and projections of the National Population Council / Consejo Nacional de Población: CONAPO). Components of the system

who care for a larger volume of patients, taking into account the final diagnsosis, will receive more money.

Implementation of this proposal will require certain legal modifications in order to harmonize different legal requirements:

1. The fourth article of the Mexican Constitution will now confirm that all persons have a right to access the SUS and receive - without restrictions - all necessary health services. Cosmetic surgery and unnecessary care would not be covered. Additionally, the laws regulating IMSS, ISSSTE, the General Health Law, the Law of Fiscal Coordination, the Federal Tax Law and the Real Estate Law will need to be rewritten to avoid conflicts in the management of the SUS. This involves:

a) Unrestricted access to health services; Provision of medical and surgical services.
b) Institutional arrangements to provide services, identity requirements for access to the system, the creation of a national patient registry, flow of money within the system, purchasing policies which might be based on capitation or fee for services.
c) Organization of the SUS into regions, institutional governance, human resources management (professional, administrative and support staff), and purchasing policies for medications, equipment and needed resources.
d) Service provision by the NHI and its institutions.
e) Relationship between the NHI and the Federal government, State governments and the social services sector.
f) Financial administration and quality control.
g) Exclusion of those services not legally covered.

2. Agreements between the SUS and other entities

a) Performance measures, financial transfer mechanisms, procedures for conflict resolution.
b) Maximum waiting times for medical care depending upon clinical complexity and acuity.
c) Criteria for monitoring therapeutic processes at different institutional levels.
d) Movement of professionals within the SUS.
e) Quality control norms as specified by the Comprehensive Quality System (SICALIDAD).

3. The SUS will be funded through tax revenues, employer contributions, via a capitated amount for the entire population.

Conclusions

This proposal for a SUS responds to the urgent need to provide comprehensive care for all Mexicans and draws upon a rights-based approach to health and social security. Internationally, publicly-based healthcare systems have been shown to be the most efficient way to provide universal coverage and attend to questions of quality, integrity, and equity.

The Latin American experience[53,54,55,56] (as well as past experiences in Mexico City[57,58]) have shown that healthcare systems can be integrated into an inclusive public system which unites the components of a fragmented system. In our opinion, an SUS that is public, integrated, and built on principles of social solidarity and equity is the best way to guarantee health to the Mexican population.

Progress towards an SUS will face political and bureaucratic challenges. Diverse sectors will need to unite in a common front to fight for health and a dignified life.

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