Analysis of Mexican Popular Health Insurance: an integrative review of literature

Análise do Seguro Popular de Saúde mexicano: uma revisão integrativa da literatura

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ABSTRACT This article aims to analyze the reform of Mexican health system, from the implementation of Popular Health Insurance, highlighting its operation, positive and negative aspects. An integrative review of the literature was conducted using Lilacs and SciELO Regional databases from January 2011 to December 2018. Publications included addressed three main themes: history of Mexican health system, its functioning and positive and negative points of the Popular Health Insurance. The literature points out that Popular Health Insurance emerged after a process of neoliberal reforms in the Mexican health system, consonant with the Universal Health Coverage proposal, which aims to reduce impoverishment by health spending in the population without social security. Popular Health Insurance offers a smaller variety of diagnoses and treatments than social security, less number of consultations, urgent care and medications. Its greatest impact was on indigenous and rural populations, but 20% of the general population remains uncovered and care is unequal still. Popular Health Insurance analysis allows us to infer possible impacts that the affordable health plans would have on the Brazilian scenario, resulting in access to a smaller set of procedures for the population currently covered by the public health system in place (SUS).

KEYWORDS Health system. Health policy. Health services reform. Mexico.

RESUMO *Esse artigo objetiva analisar a reforma do sistema de saúde mexicano, a partir da implantação do Seguro Popular de Saúde, destacando seu funcionamento, aspectos positivos e negativos. Foi realizada uma revisão integrativa da literatura nas bases Lilacs e SciELO Regional no período de janeiro de 2011 a dezembro de 2018. Foram incluídas publicações que atendiam a três questionamentos: história do sistema de saúde mexicano, seu funcionamento e pontos positivos e negativos do Seguro Popular de Saúde. A literatura aponta que o Seguro Popular surgiu após um processo de reformas neoliberais no sistema de saúde mexicano, consonante com a proposta de Cobertura Universal de Saúde, que visa reduzir o empobrecimento por gastos em saúde na população sem seguridade social. O Seguro Popular oferece menor variedade de diagnósticos e tratamentos do que a seguridade social, menor número de consultas, atendimentos de urgência e medicamentos. Seu maior impacto foi nas populações indígena e rural, mas 20% da população continua descoberta e o atendimento permanece desigual. A análise do Seguro Popular permite inferir possíveis impactos que teriam os planos de saúde acessíveis no cenário brasileiro, acarretando acesso a um elenco menor de procedimentos para a população atualmente coberta pelo Sistema Único de Saúde.*

PALAVRAS-CHAVE *Sistema de saúde. Política de saúde. Reforma dos serviços de saúde. México.*

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Introduction

Mexico is an emerging country, with large geographical dimensions and latent social inequalities. Regarding health, the country has going through an epidemiological transition characterized by the predominance of non-communicable diseases, reduction in overall mortality and increased life expectancy[1].

Considering this scenario, the influence of international entities such as the World Bank (WB), the International Monetary Fund (IMF) and the World Health Organization (WHO) in the health policies adopted by the last governments is emphasized. Most recently, these entities have been advocating the Universal Health Coverage (UHC) proposal as a way to address the new Mexican health conditions[2].

The similarity between the terms 'Universal Health Systems' and 'Universal Health Coverage' is undeniable and may contribute to conceptual misconceptions. For this reason, it is important to differentiate them, by demarcating the underlying understanding of society and State in each of these proposals.

In the first case, health is conceived as a right of citizenship through universal and equitable access, and the State is responsible for its provision and financing. The 'Universal Health Systems' have in Primary Health Care their structural axis, considered as a care network advisor, offering a comprehensive range of services, guided by the formation of bond, longitudinality and comprehensiveness. In the case of UHC, the concept of health meets an economic logic, in which the role of the State is restricted to the regulation of the system, combining public and private funding. Thus, access to services is directly related to the purchasing power of each individual or family. The approach is centered on individual care, where a restricted basket of services is offered in a fragmented manner, without care coordination or territorialization[3].

In 2012, the Mexico Declaration was signed, during the Forum on Universal Health Coverage, which placed this theme as a central element for global development[4]. Mexico is an example of trying to adopt UHC from Popular Health Insurance, a government-subsidized health plan for the population with no social security.

In order to glimpse possible developments of affordable health plans in Brazil, it was decided to review and analyze the literature on the reform of the Mexican health system, based on the implementation of Popular Health Insurance, highlighting its functioning, positive and negative aspects.

Material and methods

For this integrative literature review study[5], a search for scientific publications in the electronic databases Lilacs (Latin American and Caribbean Health Sciences Literature) and SciELO Regional (Scientific Electronic Library Online) was carried out during February 2019, both of which are open to the full texts. The descriptors used were: 'health insurance', 'health care reform', 'right to health', 'social inequity', 'health policy', 'social security', 'social health protection system', 'health reform', 'health system', 'social health protection'; associated with the word 'Mexico' and its English and Spanish equivalents.

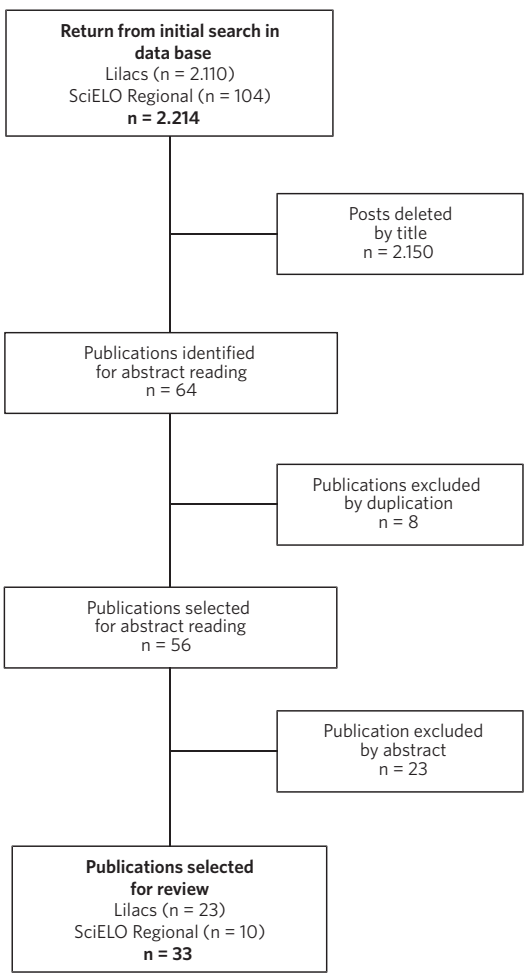
To integrate this research, publications in the full article format, free of charge, in Portuguese, English and Spanish published between January 2011 and December 2018 were included. This time frame was used by the estimate that until 2010, UHC would be implemented for all Mexicans by the Popular Health Insurance[6]. Another reason for this cut is that in 2012 the Encuesta Nacional de Salud y Nutrición (Ensanut) was conducted, a survey of data related to the health and nutrition of Mexicans, enabling comparison with the survey conducted in 2006 and,

consequently, the analysis of the implementation of the Popular Health Insurance.

The guiding questions of this review sought to describe the Mexican health system and the changes that have occurred since the implementation of Popular Insurance. The articles identified were analyzed for contributions in at least one of the following aspects: a) the Mexican health system before and during the implementation of the Popular Health Insurance; b) operation of the Popular Health Insurance, scope and coverage; c) positive and negative points of the implementation of the Popular Health Insurance in Mexico. Duplicate articles and those that did not meet the guiding questions of the research were excluded from the analysis.

Initially, 2,214 articles were found, 2,110 in Lilacs and 104 in SciELO Regional. The reading of the title was carried out, excluding 2,150 articles unrelated to the issues of interest, resulting in 64 for reading the abstracts. Of this total, 8 articles were duplicated, remaining 56. After this step, 23 articles were excluded for not being related to the issues of interest according to the summary, resulting in 33 articles for analysis, 23 in the Lilacs database and 10 in the SciELO Regional, as illustrated in *figure 1*.

Figure 1. Flowchart of integrative literature review



Source: Own elaboration.

Results

The analyzed studies were organized according to year of publication, authorship and title, as presented in *chart 1*.

Chart 1. Articles selected for literature review

Year	Author	Title
2011	Aracena-Genao B, González-Robledo MC, Gonzaléz-Robledo LM, et al.	El Fondo de Protección contra Gastos Catastróficos: tendencia, evolución y operación
2011	Contreras-Landgrave G, Tetelbron-Henrion C.	El seguro popular de salud y la reforma a las políticas de salud en el estado de México
2011	Dantés OG, Sesma S, Becerril VM, et al.	Sistema de salud de México
2011	Ortiz-Domínguez ME, Garrido-Latorr F, Orozco R, et al.	Sistema de Protección Social en Salud y calidad de la atención de hipertensión arterial y diabetes mellitus en centros de salud
2011	Laurell AC.	Los seguros de salud mexicanos: cobertura universal incierta
2011	Sosa-Rubí SG, Salinas-Rodríguez AS, Galárraga O.	Impacto del Seguro Popular en el gasto catastrófico y de bolsillo en el México rural y urbano, 2005-2008
2011	Sojo S.	Condiciones para el acceso universal a la salud en América Latina: derechos sociales, protección social y restricciones financieras y políticas
2012	Hebrero-Martínez M, Lerma RV, Trollé CM, et al.	Sociodemographic characteristics of SMNG affiliates
2012	Muñoz-Hernández O, Chertorivski-Woldenberg S, Cortés-Gallo G, et al.	The Medical Insurance for a New Generation: a viable answer for the health needs of Mexican children
2012	Nigenda G, Ruiz-Larios JÁ, Aguillar-Martínez ME, et al.	Regularización laboral de trabajadores de la salud pagados con recursos del Seguro Popular en México
2012	Pérez-Cuevas R, Doubova SV, Flores-Hernándes S, et al.	Utilization of healthcare services among children members of Medical Insurance for a New Generation
2013	Gutiérrez JP, Hernández-Ávila M.	Cobertura de protección en salud y perfil de la población sin protección en México, 2000-2012
2013	Heredia-Pi I, Serván-Mori E, Reyes-Morales H, et al.	Brechas en la cobertura de atención continua del embarazo y el parto en México
2013	Hernández-Ibarra LE, Mercado-Martínez D.	Estudio cualitativo sobre la atención médica a los enfermos crónicos en el Seguro Popular
2013	Ávila-Burgos L, Serván-Mori E, Wirtz VJ, et al.	Efectos del Seguro Popular sobre el gasto en salud en hogares mexicanos a diez años de su implementación
2013	Leyva-Flores R, Infante-Xibille C, Gutiérrez JP, et al.	Inequidad persistente en salud y acceso a los servicios para los pueblos indígenas de México, 2006-2012
2013	Nigenda-López GH, Juaréz-Ramírez C, Ruiz-Larios J, et al.	Participación social y calidad en los servicios de salud: la experiencia del aval ciudadano en México
2014	Bautista-Arredondo S, Serván-Mori E, Colchero MA, et al.	Análisis del uso de servicios ambulatorios curativos en el contexto de la reforma para la protección universal en salud en México
2014	Florez CEF, Reveiz L, Idrovo AJ, et al.	Gasto en salud, la desigualdad en el ingreso y el índice de marginación en el sistema de salud de México
2014	Gutiérrez JP, García-Saisó S, Dolci GF, et al.	Effective access to health care in Mexico
2014	Leyva-Flores , Servan-Mori E, Infante-Xibille C, et al.	Primary Health Care Utilization by the Mexican Indigenous Population: The Role of the Seguro Popular in Socially Inequitable Contexts
2015	Laurell AC.	Three Decades of Neoliberalism in Mexico: The Destruction of Society

Chart 1. (cont.)

2015	Doubova SV, Pérez-Cuevas R, Canning D, et al.	Access to healthcare and financial risk protection for older adults in Mexico: secondary data analysis of a national Survey
2015	Enciso GF, Navarro SM, Martínez MR.	Evaluación de los programas de atención a la salud de las mujeres en las principales instituciones del sistema de salud de México
2015	Mercado-Martínez FJ, Correa-Mauricio ME.	Viviendo con hemodiálises y sin seguridad social: las voces de los enfermos renales y sus familias
2015	Servan-Mori E, Heredia-Pi I, Montañez-Hernandez J, et al.	Access to Medicines by Seguro Popular Beneficiaries: Pending Tasks towards Universal Health Coverage
2015	Servan-Mori E, Wirtz V, Avilla-Burgos L, et al.	Antenatal Care Among Poor Women in Mexico in the Context of Universal Health Coverage
2015	Urquieta-Salomon JE, Villarreal HJ.	Evolution of health coverage in Mexico: evidence of progress and challenges in the Mexican health system
2015	Arredondo A, Ororzco E, Aviles R.	Evidence on equity, governance and financing after health care reform in Mexico: lessons for Latin American countries
2017	López-Arellano O, Jarillo-Soro E.	La reforma neoliberal de un sistema de salud: evidencia del caso mexicano
2018	Báscolo E, Houghton N, Riego AD.	Lógicas de transformación de los sistemas de salud en América Latina y resultados en acceso y cobertura de salud
2018	Greene J, Guanais F.	An examination of socioeconomic equity in health experiences in six Latin American and Caribbean countries
2018	Machado CV.	Políticas de Saúde na Argentina, Brasil e México: diferentes caminhos, muitos desafios

Source: Own elaboration.

The results of the review indicate that of the 33 articles selected, 20 were published in the Spanish language, 15 in the magazine 'Salud Publica de México'. The largest number of publications occurred in 2015, with emphasis on the authors Nigenda, Laurell, Servan-Mori and Gutiérrez with the largest number of publications related to the theme. It is noteworthy that Nigenda worked with the World Bank and the World Health Organization, entities of great importance in the defense of UHC.

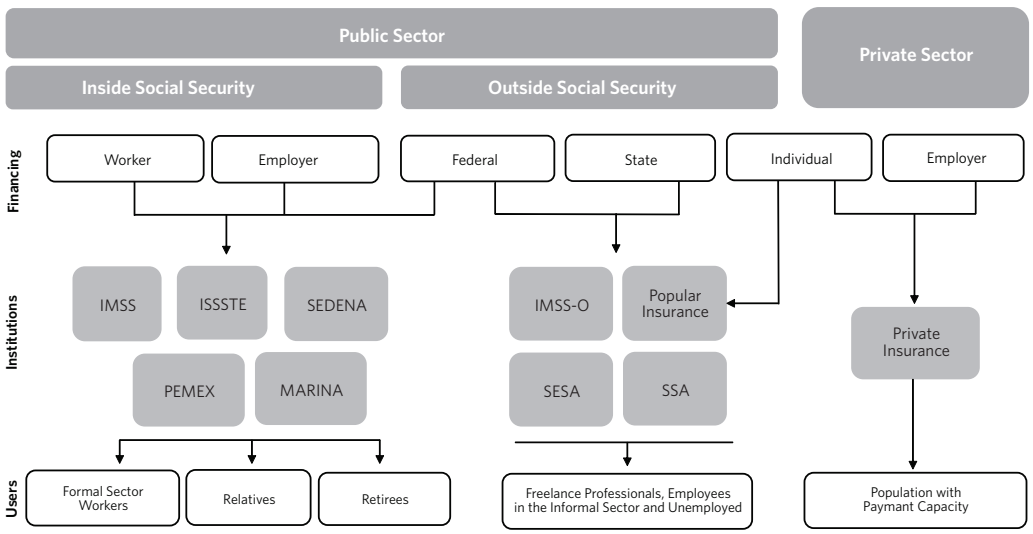
The articles were grouped into three categories of analysis to support the results and discussion, namely: 1) implementation of Popular Health Insurance; 2) functioning coverage and coverage of the Popular Health Insurance and; 3) positives and negatives of the implementation of the Popular Health Insurance.

Implementation of Popular Health Insurance

The Mexican health system is based on coexistence between public and private services, and public services are divided between the population with formal work and, therefore, with social security, and the population without social security, which has government assistance programs[1]. Historically, it can be said that there is low investment in health services for the Mexican population without social security coverage. In 2000, this population represented 60% of Mexicans, requiring payment at the time of care, indicating inequity in access to public services. Still, in 2002, the government spent two to three times more on social security than on the population without it[7].

The health system has been consolidated, therefore, in a highly fragmented manner, with the participation of numerous public institutions in the provision of health services[7], as observed in *figure 2*.

Figure 2. Mexican health system in its different institutions, forms of financing and users



Source: Adapted from Dantes, 2011[1].

IMSS=Mexican Social Security Institute; ISSSTE=Institute of State Workers Social Security and Social Services; Sedena=Secretariat of National Defense; Pemex=Mexican Oils; Semar=Secretariat of the Navy; IMSS-O=Mexican Institute of Social Security-Opportunities Program; SSA=Secretariat of Health; Sesa=State Health Services.

From *figure 2* it can be seen that there are several institutions that provide health care to formal workers, such as the Mexican Social Security Institute (IMSS) and the Institute of State Workers Social Security and Social Services (ISSSTE), while the population without formal work has other institutions, such as the Secretariat of Health, the State Health Secretariat (Sesa) and the Popular Insurance. This segmentation of the health system presents itself as a limitation to achieve equity[8].

The major changes in the Mexican health system began after the 1982 crisis, when the government of the Institutional Revolutionary Party (PRI) accepted an IMF program, in which the first step involved reducing inflation and stabilizing public finances and the second, consisted of structural reforms[9]. Healthcare reform has followed WB guidelines, stimulating market competition, reducing state intervention and offering a basic package of services[10]. The Mexican Health Foundation (Funsalud) and the National Institute of Public Health (INSP) were created by financing national and international entrepreneurs to guide these changes[11]. It is noteworthy that this process deepened the condition of poverty and inequity in Mexico, so that more than half of the population was in labor informality and helpless by social security[12].

In the early 2000s, the National Action Party (PAN) took over, appointing Julio Frenk – who served at Funsalud and INSP – as health minister. It was in his government that the Popular Health Insurance was implemented, aiming at the financial protection in health of the population without social security[11]. Popular Insurance is a voluntary insurance that covers informal sector workers without access to Social Security and offers some health interventions and specific medicines[13]. It was estimated that in 2010 or 2011 UHC would be achieved in Mexico[7].

Functioning, scope and coverage of Popular Health Insurance

The Popular Health Insurance went into operation on January 1, 2004, with the purpose of facilitating access and reducing the chance of impoverishment caused by the payment of health services[10]. Membership is made upon request, in which the individual pays a yearly renewed family allowance that entitles the direct insured, spouse, children up to 18 years and parents over 65, economically dependent[14]. The services are offered by private institutions or private providers. Ten years after its implementation, the Popular Health Insurance had 51.1 million members, which corresponded to 40% of the Mexican population[12]. Other forms of admission are the Medical Insurance for a New Generation, for children born after December 2006[15] and the Healthy Pregnancy Program for pregnant women without social security[7].

The service package provides vaccines, generalist medical consultations, diagnosis and treatment of certain diseases, dental care, family planning methods, diagnosis and treatment of fractures[14]. It also offers 285 interventions, 522 medicines listed in the Universal Health Services Catalog (Causes) and 59 interventions funded by the Fund for Protection against Catastrophic Health Expenditure (FPGC) for high-cost diseases. Catastrophic expenditure is considered to be expenditure over 30% of family income to cover health expenses. All other services are paid separately[12].

The financing of the Popular Health Insurance is federal and state, with family co-participation. Popular Insurance receives a 22.5% 'federal solidarity quota' transferred to the State Health Secretariats, which must maintain a fixed and equal quota for every affiliated family[7]. The poorest families make up the majority of affiliates and are exempt from payment[16], the rest should contribute 3 to 4% of their income. In comparison, the worker covered by the IMSS pays 0.4% of his/her salary[9,17]. Popular Health Insurance uses these resources to buy services in Sesa or, when necessary, in the private sector[1].

To ensure the strengthening of health services to affiliates, the government has invested in the infrastructure of units, with equipment purchases, staff hiring and greater availability of medicines[18]. Although Popular Health Insurance mainly covers activities at primary and secondary levels, the largest federal investment was in highly complex hospitals[7]. There was also a process of accreditation of health facilities to meet individuals covered by the Popular Health Insurance, identified as Regional Specialized Care Centers (Crae)[1].

The adhesion of the states to the Popular Insurance was significant, since in 2005 it was already implemented in 31 states. The Federal District, due to political divergence, was the last to implement it[11].

The revised articles dealt with the changes in the way of hiring employees who work for Popular Health Insurance. After extensive negotiation with the unions, there was an expansion of five and a half months to 12 months of contract and guarantee benefits such as Social Security, pension, retirement and vacation[19].

Positives and negatives points of the implementation of Popular Health Insurance

Between 2003 and 2008, there was a 0.19% fall in Gross Domestic Product (GDP) for social security[7]. Even so, in 2011, spending per person covered by social security was 3.3 times higher than that recorded by the Popular Health Insurance[20].

With regard to coverage, in 2012, Popular Health Insurance covered 38% of the population, 40.6% was covered by social security and 21.4% remained uncovered by health services[4,12].

Another difference is observed when placing diagnostic coverage side by side. While social security covers 14,900 different diagnoses, Popular Health Insurance covers only 1,556[12]. However, coverage of interventions by the Fund for Protection against Catastrophic Health Expenditure rose from 4 to 6 in 2004, to 59 in 2013, and the range of interventions offered by the Popular Health Insurance also increased over the same period from 90 to 285[12]. At first, the Popular Health Insurance had an impact on catastrophic spending only in the rural area, and today this impact is more significant in the urban area[21,22].

Although families with Popular Health Insurance still have more expenses when compared to social security, they are smaller when compared to families without coverage, with a protective effect in relation to outpatient care expenses[21,23].

Women's health care indices were considered intermediate by both social security and Popular Health Insurance[24]. However, social security guarantees continuous and higher quality care during pregnancy[25]. When compared to the group without coverage, the Popular Health Insurance showed a four times greater chance of prenatal care in adequate time[15].

Medical Insurance for a New Generation has great potential to reduce inequities in the coverage of health services offered to children[26]. However, in practice, it is found that about 25% of affiliated children did not use available services due to lack of knowledge or because their parents prefer to provide care in other services[27]. The results indicate that most children receive more outpatient care, while about 75% of mothers report delayed waiting to use available services[26]. In addition, vaccination coverage is lower than that of children covered by social security[20].

With the implementation of the Popular Health Insurance, the indigenous population presented an increase in coverage from 14% to 36% between 2006 and 2012[8,28,29], with an increase in preventive measures such as influenza vaccine and diagnosis of Type 2 Diabetes Mellitus (T2DM), but there was no change in colpocytology coverage (Papanicolaou)[29].

When compared to social security, the articles revealed that Popular Insurance offers fewer consultations, urgent care and hospitalizations[7]. It is noteworthy that the main causes of hospitalization are not covered, such as acute myocardial infarction and chronic kidney disease[6,30], and patients requiring hemodialysis may spend up to 1,500 monthly pesos with sessions, which corresponds to about 2.5% of the national minimum wage[30]. Similarly, specialized services such as incubators, blood banks, laboratories, and mammography equipment had a significant reduction in membership availability between 2008 and 2010[12]. Patients covered by the Popular Health Insurance receive only 65% of prescription medicines[31]. One of the items not available, for example, is the material for insulin therapy[32].

The opinion of health professionals regarding Popular Insurance differs according to the workplace, being more favorable in hospitals than among professionals working in health centers[33]. Affiliates, in turn, complain of lower quality inputs and lack of medicines[32]. In the urban area, there are problems such as long waiting times, lack of medicines and some services, such as dental care. In rural areas there is a lack of

trained professionals and laboratory tests, situations that imply expenses not foreseen by families[16].

Although members of the Popular Health Insurance are more likely to use the Secretariat of Health services than the uninsured population[18], a study in partnership with Harvard University found that there is no difference in the use of services among the uninsured population's and the members of the Popular Insurance, just as there is no impact on their health[7].

Discussion

Among the different conceptions of health, permeated by a political-ideological dialogue, there are two that are in dispute: one that defends universal health systems and another that defends UHC[33,34].

Universal health systems are defended by progressive governments and parties, based on the defense of health as a right and free public systems with universal and equitable access to all, according to their needs. The UHC is, in turn, a proposal of the WB, WHO and Rockefeller Foundation, which advocate subsidy policies so that the poorest people have access to health plans with less variety of services, through co-participation[34].

This process is a result of the neoliberal political advance in Latin American countries that, since the 1980s, have gone through two processes: structured pluralism, based on the separation of public functions, and the process of implementation of the UHC. In the case of Mexico, Popular Insurance is defended as a model to be followed by other countries[35]. In line with the proposed changes, Colombia, Chile, Peru, and Uruguay also carried out reforms through economic incentives aimed at the financial protection of their population[36].

Historically, Mexico has a fragmented health system in several public institutions that favor the population with formal work, which represents only half of the Mexican population. In an attempt to increase health service coverage, Popular Insurance was created in 2004 to achieve UHC and reduce health spending for the population not covered by social security.

An important advance was observed regarding the population coverage not contemplated by social security institutions after the creation of Popular Insurance. In 2000, the population without coverage corresponded to 57.6%, rising to 50% in 2006 and 21% in 2012[10]. The increased health coverage of the country, however, is in contrast to barriers to access to these services, which remain and, in the case of Mexico, reach up to 20% of the population, being more pronounced in the poorest segment[35].

Parallel to this process, population coverage by the Popular Insurance reached 38% in 2012, while social security remained at 40.6%[4,12]. Despite the improvement in these rates, after more than a decade of operation, a significant portion of the population remains without coverage. By prioritizing the most vulnerable populations, such as rural and indigenous, it is noted that these were the most benefited by the Popular Insurance[9,28,29].

Approximately 70% of the population covered by Popular Insurance uses services to control T2DM and/or hypertension[37]. Users report that consultations boil down to blood pressure measurement, weight and blood glucose testing without metabolic control or eye monitoring. After these consultations, users eventually need to pay for medications, given their unavailability[38]. Those affiliated to the Popular Insurance with SAH or T2DM have less chance of having catastrophic expenses when hospitalized, than those without the Popular Insurance[39].

Popular insurance covers 30.9% of the elderly population[20]. It is emphasized, however, the lack of coverage for more expensive diseases, which mainly affect this population. It is known that the older the age, the greater the chance of an episode of

acute myocardial infarction, cerebral hemorrhage or evolution to a chronic kidney disease, morbidities not included in the Popular Insurance, making the coverage of this population fragile and increasing their individual expenses.

In general, even with an increase in population coverage, members of the Popular Insurance have fewer consultations and urgent care per capita[7]. A lower hospitalization rate is observed, but it does not necessarily result from better health conditions in the population, but from the fact that the main causes of hospitalization are not covered by the Popular Insurance[6,30].

Another point of weakness is in relation to prescription and availability of medicines, one of the main complaints of members of the Popular Insurance. Despite having more prescription medicines in the consultations than the population without coverage, access to these medicines is restricted, being available on average 65% of what has been prescribed[12,31].

In general, the implementation of Popular Insurance has been criticized, including the fact that millions of Mexicans remain uninsured, direct disbursement spending remains high, in addition to limited access to health services and increasing inequality in access to health[11]. Nevertheless, in a study comparing six countries in Latin America and the Caribbean, Mexicans were the most optimistic about their health care system. Approximately 75% said they believed that, if they were sick, they would receive appropriate treatment[40].

Final considerations

This study was prepared to analyze the process of implementation and operation of the Popular Health Insurance in Mexico, highlighting its positive and negative points. Its implementation is a milestone in the numerous changes in this health system, consisting of social security institutions for formally working Mexicans and others for the uninsured population, for which Popular Insurance has emerged as an alternative to reducing health spending.

In fact, Popular Insurance reduces the health expenses of the affiliated population when compared to the uncovered population, but with higher expenses than social security users. Popular Insurance offers a lower variety of diagnoses and medical treatments than those provided by social security, as well as fewer appointments and emergency care. Regarding medicines, both the quantity and variety available are smaller.

Vulnerable populations, such as indigenous people and rural areas, were the ones who benefited most from Popular Insurance, mainly through the implementation of preventive measures. However, in addition to not achieving universal coverage in more than a decade of operation, Popular Insurance has created a new form of fragmentation, strengthening the unequal character of health care. Its coverage is controversial, as their affiliates must bear the costs of services and medicines not included in their list.

For a more in-depth analysis of changes in the Mexican health system and its possible advances in recent years, up-to-date data on its operation are needed, as those available in this review refer to Ensanut 2012. Another gap found is the absence of vital statistics that make it possible to compare the different types of coverage.

The analysis of the Popular Health Insurance provides good evidence of the possible impacts that health plans would have on the Brazilian health scenario, as well as from other countries with similar proposals. The principles of universality, comprehensiveness and equity are strongly contradicted when proposing the distinction of the population and its fragmentation into different services, offered in a restricted manner and

with co-participation in payment. Popular or accessible plans go against the foundations and strengthening of the single health system, and its main care and surveillance strategies such as the adoption of Primary Health Care as the entrance door of the system and coordinator of care.

Collaborators

Krasniak LC (0000-0002-8203-8840)*, Catapan SC (0000-0001-6223-1697)* and Medeiros GAR (0000-0002-7406-3210)* contributed to the conception and design of the study, analysis and interpretation of results. Calvo MCM (0000-0001-8661-7228)* critically reviewed the manuscript. ■

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