Facilitators and barriers to advancing binational health coverage strategies for undocumented Mexican migrants in the United States of America

Armando Arredondo (✉ armando.arredondo@insp.mx)

Instituto Nacional de Salud Publica <https://orcid.org/0000-0002-2768-9966>

Emanuel Orozco

National Institute of Public Health

Ana Lucia Recaman

University La Salle

Alejandra Azar

National Institute of Public Health

Research article

Keywords: Barriers, Facilitators, Migrants. Health policies, applied political analysis, social protection in health

Posted Date: October 15th, 2019

DOI: <https://doi.org/10.21203/rs.2.16134/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License. [Read Full License](#)

Abstract

Background: Within the framework of a new national health program with emphasis on universal coverage strategies and in the context of revision/adjustments to the North American Free Trade Agreement (NAFTA/TEMEC), the present study aimed to identify barriers, facilitators and challenges for the development of strategies on social protection in the health of migrants and their families.

Material and methods: Evaluative research based on a qualitative analysis with a cross-sectional design. The techniques of documentary analysis, applied political analysis (mapping of actors), in-depth interviews and case studies were used. In the first stage, key actors were mapped at the federal level and senior executives and health officials, federal deputies, senators and members of the Mexican foreign service were interviewed. In the second stage, field work was carried out in the state of Guanajuato and California; State health service officials, state government officials, municipal officials, health unit workers, representatives of CSOs and relatives of migrants were interviewed. The analysis of the interviews was carried out through the ATLAS-Ti software, as well as the mapping of actors and feasibility analysis through the POLICY MAKER software.

Results: The main results allowed to identify indicators on barriers and facilitators regarding social actors, binational agreements under NAFTA/TEMEC, institutional spaces, interaction between social actors, as well as the impact and type of relations for a greater advance in binational health policies. Several obstacles were reported, including the fears that undocumented emigrants have in the U.S. of being arrested and deported if they use public health services in the U.S. The stakeholders also believed that many Mexican emigrants do not have a culture that values health insurance.

Conclusions: In the context of reforms and adjustments of health systems that are being discussed in parallel in the revision and adjustments of NAFTA/TEMEC (United States of America, Mexico and Canada), the facilitators and barriers identified can be used to strengthen the development of bi-national strategies with different schemes of social protection in the health of undocumented migrants and their families on both sides of the border.

Introduction

In the context of reforms and changes in health systems for the 2018–2024 period (1), the analysis of governance and social protection in health for undocumented Mexican immigrants in the United States of America constitutes one of the thematic axes of binational policies (2). It is based on the need to generate evidence regarding the main indicators of governance around the demand and the provision of health services for this population, with a view to identifying barriers, facilitators, challenges and feasibility scenarios that allow the development of social protection programs in health within the framework of the recent proposals towards an Unique Health System in Mexico (3).

The issue of lack of protection in social security and health, takes on high relevance because more than half of Mexican undocumented migrants between 18 and 64 years of age do not have health insurance in Mexico or California (4). In this context, the strategy of developing new coverage strategies supported by lines of action for greater access to health services, the approach to the health needs of Mexican migrants has

allowed us to document various risk factors and health care needs. Situations suggesting barriers to access to services and medical insurance in places of origin and destination have been analyzed (5). Various analyzes have shown that the provision of social health protection services to migrants and their families is the subject of a broad debate in Mexico and the United States.

The available information on the health services offer shows that more than half of Mexican migrants aged 18 to 64 did not have health insurance (6–7). Based on this, the creation of binational health programs and public or private medical insurance has been promoted, but its implementation, implementation and possible implementation scenarios have been poorly documented (8–10).

There are initiatives aimed at carrying out events that promote access and improvement of health among Mexican residents who live and work in the United States and who do not have health insurance, such as the Binational Health Week (see: <http://hia.berkeley.edu>). The Vete Sano Regresa Sano program, where the Institute of Mexicans Abroad participates, a decentralized body of the Ministry of Foreign Affairs (11–14). However, in some studies it has been shown that since the implementation of the NAFTA, all these programs face resistance from the cultural, to the political, legal and administrative (15–18).

Initiatives have also been developed to expand the supply of health services for this population, particularly in the border area. Such is the case of organizations such as Health Net (19) and the Health Window of Mexican consulates in various US cities (20–21). These mechanisms for offering health services represent an opportunity to characterize governance mechanisms related to access to health care, especially by illegal immigrants in California. This approach seeks to identify opportunities that favor health governance through social protection and the provision of health services to a vulnerable population in a scenario of high feasibility.

In recent years, the issue of actions on social protection in health, addressed to Mexican emigrants has been raised in multiple forums, while it has been used for various purposes in the political agendas of Mexico and the United States, in favor in one case and subject to circumstances of the political and economic environment in the other (22–24). However, it requires more information, new indicators and the construction of high feasibility scenarios, to identify agreements and necessary arrangements to be able to advance in the creation of a binational health social protection system, as well as to establish its scope. in the current and future scenario (25–28).

In order to dimension the problems related to the governance and social protection in health of migrants, it is considered relevant to establish the map of actors (the normative frameworks, the processes, their interactions, etc.) linked to the creation and promotion of health services in the framework of the national health program 2018–2024 (29–31). To this end, the review of trade agreements on programs, services and medical insurance was examined, as well as an analysis of the legal frameworks that support the supply and access to health services in both countries, incorporating economic indicators of equity and access to health (32–33). On the other hand, it is also very important to identify the key social actors involved, as well as the type of interactions and interaction spaces between the different actors of the health system. This information is strategic in the identification of governance indicators and their relationship with facilitators,

barriers and challenges for a public policy of greater social protection in health for the benefit of migrants (34–36).

In summary, the objective of this manuscript is to present the main indicators on facilitators and barriers for the implementation of binational strategies in the area of social protection in the health of migrants.

Methodology

An evaluative research design was developed based on qualitative analysis of key documents, in-depth interviews with key actors and case studies in localities of Guanajuato, Mexico and California, US. Both states were selected at their convenience, in response to a binational call, which proposed involving academic institutions from Mexico and the United States with a large influx of migrants. Under a collaborative scheme with colleagues from University of California in Los Angeles, contact was made in the field with Mexican families from Guanajuato, who had the destination of the state of California, which further strengthened the collaboration and political mapping. The “snowball” method was used to carry out the interviews, combining two strategies; In the first case, the government actors contacted each other directly, sending them letters and emails. With the state actors, some personal recommendations were used with families and members of migrant federations, who in turn recommended other contacts from which the interviews were conducted. The methodological procedures comprised three stages:

Stage 1: Documentary analysis of commercial and migratory agreements. The documentary review combined library work and internet searches. The descriptors used were: Mexico-United States migration, health insurance, social protection in health, health governance. The electronic searches were made with the Scholar Google search engine. The documentary sources selected for the review were 35, including commercial treaties, migration agreements and academic documents generated by binational health commissions.

Stage 2: Conduct case studies through ethnographic fieldwork in communities of origin of migrants in Mexico and in destination communities in California, in the United States. Saturation criteria were used to establish a relevant quota in the estimated number of networks and key informants.

Stage 3: Supported by the Policy Maker software, the political analysis was carried out to identify the main indicators of governance, as well as the facilitators and determinant barriers on the feasibility of binational health insurance for undocumented migrants. The methodology of political analysis is a systematic process that starts from the definition of the government agendas established and executed by the identified actors. The key topic explored was the social protection of undocumented Mexican immigrants in the United States, as well as the definition of the role of these actors in the attention to this need of accessibility to health services that affects this population. Supported by the Atlas-Ti v. 5 software, the information from the interviews with key actors allowed us to analyze and interpret the operational meaning of the political agenda to define barriers and facilitators aimed at the implementation of strategies for bi-national cooperation for social protection in the health of undocumented migrants.

Results

The main findings are presented in three sections, the first includes a list of the facilitators and barriers that were identified from the documentary review; The second section includes the characterization and type of facilitators and barriers, explicitly stating the source of origin, the category, the participants, the action to be explored and the level of impact or feasibility. The third results section includes the list of the 10 main causes or the origin of the facilitators and the barriers identified.

Binational facilitators on health coverage strategies for migrants and their families.

The main integrated facilitators are highlighted below based on the recommendations, suggestions and findings of the sources of information selected and reviewed for that purpose. The NAFTA documents, government reform projects as well as national and international Civil Society Organizations (CSOs), make recommendations for a binational health policy. In this context, they establish that the challenges of the social protection system in health tend to coincide with the challenges of the national economy, in the sense of increasing access, coverage and quality at the lowest possible cost and improving administration to increase the efficiency. To address these challenges, as opportunities or facilitators to develop, the following aspects are highlighted:

- New mechanisms to standardize and certify units of medical care, licensing and certification of professionals, technology assessment and financial equity, and adjustments of the regulatory framework based on recommendations issued by the World Health Organization, which establish the expansion of public offer through participation of public and private providers.
- From the design of reform programs in social protection in health for different population groups, take advantage of the development of the wide range of commercial and investment transactions that operate within the framework of NAFTA/TEMEC through trilateral governmental and non-governmental institutions (including health aspects).
- There is already a normative framework that establishes that there must be a trilateral or binational cooperation (Mexico-US-Canada) regarding the migration issue and collateral problems such as social protection. This opening includes the development of including new and innovative legal migration routes, new and effective mechanisms for law enforcement with rights and obligations in the workplace and a series of welfare support mechanisms to strengthen the supply of jobs and social protection programs.
- Strengthen the binational dialogue to find beneficial solutions to the migratory phenomenon in general, and to the resolution on social protection actions in the particular. This will allow the improvement of policy coordination and management within each government, both at the federal and state and municipal levels.
- Binational agreements have been signed for cooperation in health and education. Such agreements have been promoted between the health and labor authorities of Mexico and the US. These agreements make it

easier for Mexicans in the United States to access information about health and education services available to them. In a context of more legal migration and less illegal, the bilateral cooperation of these agreements proposes to develop binational health coverage schemes, including those that give attention to undocumented workers.

- From the perspective of some US analysts, it was promising that the reform of the Mexican health system 2018–2024, contemplates extending the coverage to more Mexicans, implementing managerial care schemes and having guidance to expand the supply of private services. This is based on documents and very specific studies where it is established that where there is less service coverage, the population spends more out of pocket in private providers (California Health Care Foundation, 1999–2018, SSA, 2018).

Barriers to a binational health policy on health coverage strategies for migrants and their families.

Regarding the barriers identified in the documentary analysis, the repercussions of NAFTA/TEMEC on health systems continue to be valid. In effect, the framework promoted and continues to promote North American and Mexican medical agencies and institutions, both public and private, to initiate joint commercial projects to consolidate public and private insurance in principle. The argument to favor this expansion is precisely that the growth of this industry should be coupled with the strengthening of supply and within the framework of production and regulation of public and private health services that health reform programs propose, both in Mexico as in the US. Despite the advances in agreements and joint actions, there are still important limitations or resistances. It is in this sense that among the main current barriers we can highlight the following:

- There are limitations regarding the regulation of health insurers in Mexico, which limit a foreign company to control a certain percentage of the domestic insurance market.
- The transnational scope of actions of the health system of the United States in Mexico is generally limited to preventing the spread of infectious-contagious diseases originating in Mexico in its transit to North American territory.
- Different documents express that from the Mexican side there are conceptual and normative differences as barriers for bilateral cooperation in matters of public health and social protection in health.
- Unlike situations related to public health, Mexican private doctors expressed more interest than their counterparts in the development of coordination mechanisms for medical care, pointing out various forms of lack of reciprocity of doctors from the United States.
- The opinions of American doctors in this regard coincide with some problems referred to in recent years, such as the perception that Mexican doctors are not adequately trained.
- Since the implementation of NAFTA, there has been a lack of definition of frameworks for the implementation of binational programs in the field of health systems.

- Binational initiatives are described where the changes in both governments tended to paralyze the scope of the actions due to the lack of correspondence of the regulatory frameworks. For example, it highlights the experience of the United States-Mexico Border Health Commission, which was formulated in the 1990s by the United States-Mexico Border Health Association. This commission was approved by the Congress of the United States in 1994 and received federal funds in 1998. Due to the lack of understanding of the governments, it had its first meeting in 2000, the year in which the Mexican government approved it. This commission did not go beyond defining its structure and decision-making processes. By 2018 its mandate remained vague.
- Limitations of interaction between different social actors involved in the development of health programs. For health professionals, customs personnel are problematic for the development of binational actions in health matters. Despite the existence of agreements aimed at facilitating actions of different health programs, the interpretation of such agreements by agents of both countries creates asymmetric situations.
- There are cultural barriers in accessing health programs that migrants could use.
- Relevant cultural barriers also appear among health providers. In fact, despite sharing different cultural patterns, there are variables of political culture that generate relations of distrust between decision makers of both countries. A relevant aspect is that their health systems respond to different values; In Mexico, the social health protection system is inspired by solidarity and financial protection, while in the United States it is inspired by market principles.

Characterization and origin of facilitators and barriers.

As part of the results of the in-depth interviews and the case study, the main indicators on the characterization of facilitators and barriers to advance in the area of social protection in the health of migrants are presented below from the perspective of social actors Mexico.

The analysis of the facilitators to advance in the social protection of the health of the migrants, was aimed at improving the feasibility of the analyzed policy and favors the identification of actions that should be taken advantage of to take advantage of the opportunities highlighted below. This analysis involved identifying the sources of facilitator, describing the opportunity punctually, linking them with actors, requiring the definition of actions to take advantage of the facilitator and favoring an evaluation of their chances of success.

Given the weight that the Mexican State has had, and that it is expected to have for the period 2018–2024, in the formulation of public policies and in the attention of the social needs of the population, almost all of these opportunities have as a source the own radius of action of the Mexican government and its instances related to the protection of health on both sides of the border. Only in the case of facilitators linked to CSOs, is established as a source “another organization”.

Eight facilitators were identified, of which four were qualified with a high prospect and four with a medium prospect. Table 1 presents the facilitators with high impact prospects, while linking them with groups of potential actors and coalitions to exploit them.

Facilitators with a medium impact prospect are described in table 2, and include actors from the social and government sectors, as well as CSOs. This pattern suggests that the greatest opportunities were concentrated in political and governmental actors at the federal level, while, to the extent that the analysis is directed at the local level, greater barriers and feasibility challenges are outlined.

One of the dimensions described in the actors section is the existence and identification of considerable barriers to the policy goals, which are presented in table 3. These obstacles are analyzed as factors that reduce the feasibility of the policy goals, but they establish at the same time the definition of actions to overcome obstacles.

The results also suggest that the sources and origin of the barriers are organizational and political environment, having analyzed a total of seven. The same table 3, allows to observe that four obstacles are of high level and three of medium level. High level obstacles are related to governmental actors at the federal level, government actors at the state level and actors in the social sector. On the other hand, medium level obstacles were related to political actors, CSOs and governmental actors at the municipal level.

Finally, regarding the results on the origin of the main facilitators and barriers, in Tables 4 and 5, the type of indicator and the possible cause (organizational, political, cultural, geographic, or financial) are identified more specifically and explicitly. The purpose of this is to identify the decision space to strengthen the impact in the case of the facilitators and to reduce or eliminate the impact in the case of barriers.

Discussion

The results suggest that high-impact facilitators are mainly related to the interest in binational health insurance for undocumented migrants from governmental and political actors with the ability to influence decision-making. The actions to strengthen the identified facilitators involve three steps: informing decision-makers, maintaining political links with key actors and establishing the bases for obtaining infrastructure resources and programs for the health of migrants.

The actions related to informing decision makers derived from the position of these actors to demand information to promote initiatives within their legislative commissions, strengthening legal frameworks related to the protection of health under a binational approach. On the other hand, the link with key actors supposes that maintaining it would help the tasks of promotion and awareness for decision making. Regarding the offer of more health programs for migrants and their families, it is something that suggests working together with key actors of legislative commissions on both sides of the border.

Medium impact facilitators are related to the possibility of involving stakeholders from the communities visited in the implementation of pilot programs for migrants, as well as the interest of state and municipal governments to involve migrants and their communities of origin in projects of development to expand social protection in health at the state level. There was also an important level of recognition of the achievements of CSOs at the community level; Some of these organizations guarantee promoting proposals for binational health insurance within the communities where they perform their work (California).

Regarding the identified barriers, they affect both the goal of strengthening government capacities and the improvement of accessibility to health services through public insurance. For the ministry of health actor, different evaluations made to the Popular Health Insurance program establish important challenges for financial sustainability and the fulfillment of the goal of ensuring 100% of the population without social security, which by 2018 is still not fulfilled. This suggests questions about the ability of the Mexican government to extend this offer to people outside the national territory. Key actors of the foreign service pointed out relevant barriers of the legal framework in both countries, as well as the permanent pressure of the character and conjunctures of the bilateral relationship at the macro level, particularly in the framework of the new negotiations and revision of NAFTA/TEMEC. These actors pointed out that the offer of public health services for Mexicans in the United States includes preventive programs that are implemented from the consular offices, as well as initiatives such as Social Security Institute-Migrants, which affiliate people in the United States but can only exercise this benefit in the Mexican territory.

Another important point reported as a barrier is the use of remittances and their paradoxical effects. This aspect that in the case of private health insurance is an opportunity, in the case of public health policies, remittances pose a barrier to overcome. In effect, social protection strategies from the public health system, far from extracting the scarce resources of migrants, should guarantee mechanisms of financial protection and reduction of catastrophic expenditures for damage to health.

Conclusions

Finally, to conclude, in order to strengthen the development of bi-national strategies with different schemes of social protection in the health of undocumented migrants, we would like to highlight the main facilitators and barriers based on the results of the study:

In relation to facilitators, the first facilitator refers to the broad interest of the deputies to carry out a binational consultation to develop and promote a new initiative on the issue of social protection in the health of migrants. For this consultation, the social actors that would participate and the central themes to be developed were also identified for the feasibility analysis of new social protection strategies under a universal coverage scheme within the framework of the National Health Program 2018–2024. The second is the development of a binational meeting to promote binational health insurance under a public insurance scheme. A third facilitator was the proposal of the Mexican foreign service to develop a binational program of promotion and monitoring of social health protection actions aimed at migrants and their families on both sides of the border. The fourth facilitator is the proposal of the SSA-state level to establish with the SSA-federal level, working groups, mechanisms and actions to identify infrastructure, resources and programs to extend social protection to migrants and their families. We also highlight the proposal for the development of pilot studies that evaluate, on both sides of the border, the implementation of the extension of coverage of social protection in health through a new modality aimed at migrants.

With regard to barriers, it is important to highlight the most significant barriers: the limitation of the state level in the generation of new services, the paradoxical effects of remittances in terms of financial protection in health, the low interest of some community actors in health insurance, instability in bilateral relations depending on changes of actors and policy in the binational sphere, the high tendency to limit programs for

migrants to health promotion, lack of fulfillment of goals set out in the origin of the social protection system, the emphasis on the development of infrastructure projects in migrant communities does not include infrastructure for problems of social protection in health, CSOs, the passive role of community groups and family networks in decisions regarding social protection strategies in health, lack of evaluation indicators on the challenges and challenges in terms of social protection in the health of migrants and their families.

Declarations

Authors' contributions

AA participated in the study concept and design. AA, EO and ALR participated in the acquisition of subjects and data, analysis and interpretation of data, preparation of manuscript. AA, EO, ALR, and AAz participated in the analysis and interpretation of data, preparation and review of manuscript. All authors read and approved the final manuscript.

Ethical Approval and Consent to participate.

The protocol of this research was reviewed and approved by the Research and Ethics Committee of the National Institute of Public Health, including the Consent to participate. The protocol also was reviewed and approved by the University of California Los Angeles Office for the Protection of Human Subjects.

Consent for publication

Not applicable

Availability of supporting data

Not applicable

Acknowledgements

Not applicable

Competing interests

None declared.

Funding

This project received financing funds from USMEXUS Program University of Berkley. This organism does not have any role in the design of the study, the compilation, the analysis, the interpretation of results or the writing of the manuscript.

List of abbreviations

North American Free Trade Agreement (NAFTA/TEMEC)

United States (US)

Civil Society Organizations (CSOs)

References

- 1) SSA. Plan Nacional de Salud 2019–2024. 2019. Gobierno de la Republica.
[https://www.gob.mx/salud/articulos/incrementar-el-acceso-a-la-salud-para-todos-los-mexicanos?idiom = es](https://www.gob.mx/salud/articulos/incrementar-el-acceso-a-la-salud-para-todos-los-mexicanos?idiom=es) (accessed Feb, 19, 2019)
- 2) Cochran N. Binational collaboration in health and medical research between the United States and Mexico, en: Warner D. NAFTA and trade in medical services between the U.S. and Mexico, U.S.—Mexican Policy Studies Program, Policy Report No. 7, University of Texas, USA, 2017: 1–28.
- 4) Arredondo A. et al. "Temas Selectos en Sistemas de Salud: Costos, Financiamiento, Equidad y Gobernanza. Conceptos, Tendencias y Evidencias " Univ de Montreal/Univ. Aut. de Yucatán. 2016: 1–212.
- 4) California Health Care Foundation (CHCF). Cross border health insurance. An overview, CHCF—Healthcare Redesign International, USA, 1999: 16–19.
- 5) Bronfman M y Díaz Polanco J. La cooperación técnica internacional y las políticas de salud. *Ciênc. saúde coletiva*, 2003, vol.8, no.1, p.227–241.
- 6) Iniciativa de Salud México California (ISMECAL). Historias de ir y venir y la salud mental: manual para promoción de la salud, Iniciativa de Salud México California, Berkeley, USA, 2003, pp. 2–50
- 7) Hall R y Rivera L. Trade in health care products between the United States and Mexico, en: Warner D. NAFTA and trade in medical services between the U.S. and Mexico, U.S.—Mexican Policy Studies Program, Policy Report No. 7, University of Texas, USA, 1997: 98–113.
- 8) Tuirán R. Migración México—Estados Unidos. Hacia una nueva agenda bilateral, Documento Técnico del Consejo Nacional de Población, México, 2012: 3–15.
- 9) Academia Nacional de Medicina (ANM). El Tratado de Libre Comercio y los Servicios Médicos, ANM - Comisión Mexicana de Investigación en Salud, México, 1994:44–71.

- 10) US Department of State. 2005. Joint statement by president Bush, president Fox, and prime Minister Martin: Security and prosperity partnership of North America, <https://2001-2009.state.gov/p/wha/rls/prsrl/2005/69850.htm> (January 20, 2019).
- 11) Secretaría de Salud (SSA). La democratización de la salud en México. Programa Nacional de Salud 2001-2006, México, 2011: 1-167.
- 12) Secretaría de Salud (SSA). Programa Nacional de Salud 2007-2012, México, 2013: 1-19.
- 13) Agencia Mexicana de Cooperación Internacional para el Desarrollo. (2017). ¿Qué es la cooperación internacional para el desarrollo en <http://www.gob.mx/amexcid/acciones-y-programas/que-es-la-cooperacion-internacional-para-el-desarrollo-29339> (accessed, April 20, 2019).
- 14) Figueroa, B. El nuevo rostro de la cooperación internacional mexicana. Acuerdos y tratados internacionales en política social. Revista Mexicana de Política Exterior, 2014, 102(s/n): 7-14.
- 15) Homedes N, Ugalde A. The North American free trade agreement and public health at the US-Mexico border, American Journal of Public Health, 2004, No. 7.
- 16) Gómez-Dantés O, Frenk J, Cruz C. Commerce in health services in North America within the context of the North American Free Trade Agreement, Revista Panamericana de Salud Pública, 1997, Vol 1, (6):327-33.
- 17) Frenk J, Gómez Dantés O, Cruz C, Chacón F, Hernández P y Freeman P. Consequences of the North American Free Trade Agreement for Health Services: A perspective from Mexico, American Journal of Public Health, 1994, Vol. 84, No. 10.
- 18) Franco G., Á., y Álvarez D., C. Salud pública global: Un desafío a los límites de la salud internacional a propósito de la epidemia de influenza humana A. Revista Panamericana de Salud Pública, 2009, 25(6): 540-546.
- 19) Health Net. Guía de ventajas y beneficios de su plan de salud, California, 2013 (Tríptico):1-2.
- 20) Secretaría de Salud (SSA). Programa de Reforma del Sector Salud 2001-2006, Poder Ejecutivo Federal, México. 2001: 183-229.
- 21) Secretaría de Salud. Cobertura universal, objetivo de SSA. 2018, http://www.seguro-popular.salud.gob.mx/index.php?option=com_content&view=article&id=105:cobertura-universal-en-2012-objetivo-de-ssa&catid=5:comunicados&Itemid=46 (accessed, April 17, 2019).
- 22) Observatorio de la Migración (2010-2017), «La Reforma de salud en Estados Unidos», Observatorio de la migración, http://www.observatoriodelamigracion.org/om/La_reforma_de_salud_en_Estados_Unidos.html (accessed, Feb 19, 2019).

- 23) Fidler D., P. The globalization of public health: The first 100 years of international health diplomacy. *Bulletin of the World Health Organization*, 79(9): 842–849. en: <https://dx.doi.org/10.1590/> (accessed April 11, 2019)
- 24) Wassink, JT. Implications of Mexican Health Care Reform on the Health Coverage of Nonmigrants and Returning Migrants. *Am Jou of Public Health*, 2016, Vol 106, No. 5: 848–850.
- 25) Holzman y J. Manejo social del riesgo: un nuevo marco conceptual para la protección social y más allá, *Revista de la Facultad Nacional de Salud Pública*, 2003. Vol. 21, No. 1: 73–106
- 26) Canales A. Migración y trabajo en la era de la globalización: el caso de la migración México-Estados Unidos en la década de 1990, *Papeles de Migración*, No. 33, 2017
- 27) Cámara de Diputados (2). El impacto de las remesas familiares en México y su uso productivo, Centro de Estudios Sociales y de Opinión Pública, (LIX Legislatura), México, 2016:1–47.
- 28) Seade J, Aspectos clave del nuevo Tratado Comercial TEMEC 2019.
<https://www.camescom.com.mx/presenta-seade-claves-del-nuevo-tratado-comercial-entre-mexico-eua-canada-temec/> (Accessed March 15,2019)
- 29) Arredondo a, Ruiz J, Wins C. Estrategias y mecanismos de extensión de cobertura en salud y seguridad social en Paraguay, II parte”. *Rev Seguridad e Higiene*, 2018. Vol 42: 12–14
- 30) Boismenu, Gérard and Alain Noël. La restructuration de la protection sociale en Amérique du Nord et en Europe, *Cahiers de Recherche Sociologique*, 1995, No.24: 38–51.
- 31) Secretaria de Salud. Gobierno de la Republica 2013–2018. Sistema de Protección Social en Salud. Elementos conceptuales, financieros y operativos. México DF, 2018: 3–37.
- 32) Wallace S, Gutiérrez V, Castañeda X. Access to Preventive Services for Adults of Mexican Origin. *Journal of Immigrant and Minority Health*. 2008, 10(4): 363–371.
- 33) Arredondo A. et Nájera P. Équite et accessibilité de la santé au Mexique? Évaluation économique du processus de recherche et d’obtention de services. *Santé et Systemique*, 2016, Vol. 9(3): 71–86.
- 34) Tenorio Corro Y., Arredondo A. Utilización de los servicios de salud en la población migrante de Estados Unidos. *Horizonte sanitario*, mayo - agosto 2018. Vol. 17, No. 2: 89–94
- 35) Hufty M. et al. Gobernanza en salud: un aporte conceptual y analítico para la investigación. *Cad. Saúde Pública*, 2006, Vol.22: 535–545.
- 36) Arredondo A., Azar A. and Recaman A. L. Challenges and dilemmas on universal coverage for non-communicable diseases in middle-income countries: evidence and lessons from Mexico. *Globalization and Health*, 2018. Vol. 14, No.1: 89, 1–10.

Tables

Table 1: Facilitators with high impact for the advancement of binational strategies in terms of health coverage for migrants.

Facilitator Source	Facilitator/opportunity	Stakeholders	Action to explore the opportunity	Effect
Mexican government, Federal Executive Branch	Interest in the Chamber of Deputies for the topic and offer of contacts for consultation and eventual promotion of a legislative initiative on the topic of social health protection for undocumented migrants.	-Congress Opinion Studies Center. -Vulnerable Groups Committee of the Congress. -Congress Health Commission.	Inform stakeholders about the feasibility analysis and potential strategies to legislate in favor of social protection in undocumented migrants.	High
Mexican government, state level.	Interest in binational health insurance and offer of advice and contacts for discussion. Offer to promote results in binational meeting of governors.	- Border Affairs Committee of the Senate. - Social Security Committee of the the Senate.	Inform the stakeholders about the feasibility analysis and potential strategies to legislate in favor of social protection in undocumented migrants.	High
Mexican government, federal level.	Broad interest of the Mexican Foreign Service in favoring binational policies of social protection in health for undocumented emigrants.	- Border Health Commission (Ministry of Foreign Affairs (SRE)). - Ambassadors of the Mexican Foreign Service.	Maintain the link and send research results to promote binational collaboration on social protection in health for undocumented migrants.	High
Mexican government, federal level.	Interest of the SSA (Ministry of Health) in the subject. The Ministry of Health is from Guanajuato and has been involved with the subject.	- Directorate of International Affairs SSA. - State SSA - Health and Migrant Commissions of the State Congress.	Encourage the link with the federal SSA to promote opportunities for the development of governmental capacities to extend social protection to undocumented migrants in coordination with the states and municipalities targeted.	High

Table 2: Facilitators with a medium prospect for advancing binational strategies in terms of social protection of migrants' health.

Facilitator Source	Facilitator/opportunity	Stakeholders	Action to explore the opportunity	Prospect
Mexican government	Broad opportunity to strengthen social protection in populations of origin for community actors by the offer of government programs (Popular Insurance "3 x 1")	<ul style="list-style-type: none"> - Embroiderers Association of "El Gusano". - Relatives of migrants (Mineral de la Luz, Gto.) 	Focus actions of governmental programs in communities of very high and high marginalization.	Medium
State government	Interest of the state government in strengthening the linkage of undocumented migrants for the development of community and regional development projects.	<ul style="list-style-type: none"> - Migrant's House (Cortazar, Gto.) - Office of Immigration Affairs, Guanajuato. 	Inform state and municipal decision makers about different planning and financing options for social protection projects in health.	Medium
Federal and State government	Possibility of implementing pilot programs under the responsibility of the state health services, given the interest of federal and local actors in binational insurance.	<ul style="list-style-type: none"> - Department of Epidemiology (Guanajuato Ministry of Health (SSG)). - Migrant Health Program (Guanajuato Ministry of Health (SSG)). 	Send information to stakeholders and strengthen their links with local actors participating in development projects in community and regional development projects.	Medium
Civil Organizations	Recognition of community work of civil organizations and linking them with development projects at the community, municipal and regional levels.	<ul style="list-style-type: none"> - Agricultural Development Center. - Community Foundation of Bajío. - Dishani Community Foundation. - International Health Services. 	To give continuity to this involvement, favoring a greater participation in the consultation and piloting of social protection initiatives.	Medium

Table 3: Definition of barriers for the advancement of binational strategies in terms of health coverage of migrants.

Sources of Barriers / Obstacles	Barriers	Stakeholders	Action to explore the opportunity	Effect
Federal Executive Branch (SSA)	State limitation in the offer of health services for uninsured population and low interest of community actors in health insurance	<ul style="list-style-type: none"> - Embroiderers Association of "El Gusano". - Relatives of migrants (Mineral de la Luz, Gto.) 	Strengthen the capacities of the state health system in the targeting of actions in communities with accessibility barriers.	High
Political environment	The foreign service agenda may be subject to the variability in bilateral relations; the provision of health services is not a priority and is limited to consular services.	<ul style="list-style-type: none"> - Border Health Commission (SRE). - Ambassadors of the Mexican Foreign Service. 	Schemes for the provision of services that satisfy priority demands and comply with legal frameworks for collaboration.	High
Federal Executive Branch (SSA)	Important challenges are faced at a national level to comply with the assurance goal for "Popular Insurance" in the national population.	- Directorate of International Affairs SSA.	Strengthen the scope of social protection in Mexico to create extension conditions.	High
State government	Emphasis on community infrastructure development projects with low attention to problems of social protection in health.	<ul style="list-style-type: none"> -Migrant's House (Cortazar, Gto.) - Office of Immigration Affairs, Guanajuato. 	Provide information to decision makers at the state and municipal levels about the effects of social protection on social welfare.	Medium
Civil Organizations	The scope of civil organizations actions is limited; they also face organizational and financing problems.	<ul style="list-style-type: none"> - Agricultural Development Center - Community Foundation of Bajío - Dishani Community Foundation - International Health Services (NGO) 	Greater involvement of civil organizations in the identification of state priorities and links with social protection initiatives in health.	Medium
Federal and State government, Legislative Branch.	Some disinformation was observed about the social protection problem in emigrants; possibility of promoting results through parties and not as a citizen initiative.	<ul style="list-style-type: none"> - Congress Opinion Studies Center. - Border Affairs Committee of the Senate. - Congress Health Commission. - Social Security Committee of the the Senate. 	Greater empowerment of emigrants; participation with demands on financing mechanisms and promotion of binational insurance in forums such as the Migrant Parliament.	Medium

Table 4: Top 10 causes of barriers to migrants and their families to health coverage programs after the reforms of the health system in Mexico.

Type of Barrier	Barrier
Political	1- Limitations on the level of state government in generating new health services that respond to the increased demand caused by the growth in the number of families enrolled in the program of universal coverage.
Financial.	2- Paradoxical effects of remittances in terms of financial protection in health. The increase in remittances from migrants-family promotes addressed invest more in private institutions than in public institutions where is offered the health coverage program.
Financial.	3- Problems of financial sustainability to ensure all inputs required for free in all interventions and total coverage of medicines under the new effective universal coverage scheme.
Organizational.	4- Little interest and motivation in the new insurance schemes for major medical expenses, mainly due to the expectation of offering free services to all public sector institutions.
Cultural-organizational	5- Uncertainty generated by ignorance of users about that problems can be addressed from the basic package services of popular health insurance and which are not.
Organizational	6- High tendency to limit migrant programs to basic programs of promotion and prevention and poorly to treatment and rehabilitation.
Cultural-organizational.	7- Perception of poor quality of care, especially in the treatment of chronic diseases such as diabetes and hypertension.
Geographical.	8- Geographical access problems due to lack of transport or topographic difficulty to access easily from home to health center assigned.
Cultural-organizational.	9- Users, networks migrant families and community groups continue to have a passive role in decisions about the balance between what they need and what insurance coverage offers.
Organizational.	10- Absence of reliable indicators and targets to assess performance and effective coverage in addressing health problems of migrants and their families.

Table 5: Top 10 causes of facilitator to migrants and their families to health coverage programs after the reforms of the health system in Mexico.

Type of Facilitator	Facilitator
Political.	1- Broad opportunity to strengthen social protection in populations of origin for community actors by the offer of government programs (Popular Insurance "3 x 1").
Financial.	2- Within the framework of the New National Health Program 2018-2024, new schemes of universal coverage in Mexican territory are proposed with free health services and supply of medicines for the mere fact of being a Mexican citizen.
Financial.	3- Review and adjustments for the strengthening of the programs in consulates of the USA under the scheme of health booth greater coverage in migrants and their families.
Organizational.	4- In the states of Mexico where agreements have already been signed for the transition from popular insurance to full coverage schemes, inform civil society organizations involved in migrant groups to incorporate migrant families under the new effective universal coverage schemes (including free attention to any health problems and medications).
Cultural-organizational.	5-Within the framework of the new public administration of the Mexican government 2018-2024, development of new agreements in binational health programs that include collaboration schemes from research and assistance in health needs of Mexican migrants and their families on both sides of the border.
Organizational.	6- There are new schemes for greater interaction between committees of the legislative branch (migration, health and social security commissions), community leaders and civil society organizations for the development and monitoring of welfare programs, including health needs.
Cultural-organizational.	7- The new national health program 2018-2024 includes the design and strategies for continuous improvement in the quality of care.
Geographical.	8- From the Ministry of Communication and Transportation and Social Welfare, a proposal is being developed to implement a road infrastructure development plan that allows greater access of marginalized communities to public services, including health services.
Cultural-organizational.	9- The current program of coverage has contemplated that by 2024 in all the states of the country a promotion, detection and prevention plan has been implemented with a broad participation of users in public health activities.
Organizational.	10- The National Council of Humanities, Science and Technology is rethinking the support of financial resources to emphasize and promote the development of research and generation of knowledge on evaluation indicators that guarantee the effective implementation of the different programs and policies of the new development plan, among them the new health programs and policies.