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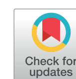
Qualitative analysis of governance trends after health system reforms in Latin America: lessons from Mexico



A. Arredondo [a,*], E. Orozco [a], A.L. Recaman [b]

[a] National Institute of Public Health, Mexico
[b] University La Salle, Cuernavaca, Mexico

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ABSTRACT

Objective: Health policies in Latin America are centered on the democratization of health. Since 2003, during the last generation of reforms, health systems in this region have promoted governance strategies for better agreements between governments, institutions, and civil society. In this context, we develop an evaluative research to identify trends and evidence of governance after health care reforms in six regions of Mexico.

Methods: Evaluative research was developed with a retrospective design based on qualitative analysis. Primary data were obtained from 189 semi-structured interviews with purposively selected health care professionals and key informants. Secondary data were extracted from a selection of 95 official documents on results of the reform project at the national level, national health policies, and lines of action for good governance. Data processing and analysis were performed using ATLAS.ti and PolicyMaker.

Results: A list of main strengths and weaknesses is presented as evidence of health system governance. Accountability at the federal level remains prescriptive; in the regions, a system of accountability and transparency in the allocation of resources and in terms of health democratization strategies is still absent.

Conclusion: Social protection and decentralization schemes are strategies that have allowed for improvements with a proactive role of users and civil society. Regarding challenges, there are still low levels of governance and difficulties in the effective conduct of programs and reform strategies together with a lack of precision in the rules and roles of the different actors of the health system.

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Introduction

The reforms carried out to improve the production, financing, and distribution of health services require an analysis of the strengths and weaknesses that have occurred in their implementation. This is particularly necessary and relevant in the case of the different universal coverage schemes that have been implemented in the last 20 years in Latin America. The case of Mexico can be illustrative, especially because of the

* *Corresponding author*. Instituto Nacional de Salud Publica-Mexico, Av Universidad 655. Col. Sta Maria Ahuacatitlan, Cuernavaca CP 62508, Mexico.
E-mail address: armando.arredondo@insp.mx (A. Arredondo).
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broad and intense project of reforms that have been implemented and evaluated in the last decade.[1–3]

Although principles of equity, financial protection, and quality of care have been advanced, these reforms have not changed the traditional segmentation of health service provision in three subsystems: health services for the insured population (public services for the population of the formal economy); the subsystem for the uninsured population (public services for population outside the formal economy and with the highest levels of marginalization); and the subsystem for the population with purchasing power (private sector). The subsystem of public health services for the uninsured, and particularly the priority programs for the most marginalized groups, is the object of analysis of this manuscript.[4,5]

As with most Latin American countries (including Colombia, Chile, Brazil, and Argentina),[6] since the 1980s, Mexico implemented policies governed by the principle of decentralization and social protection schemes, under which low-cost essential services packages were implemented for low-income populations outside the formal economy. Under this principle, and as part of the latest generation of health reforms, the National System of Social Protection in Health (SNPSS) was created, which sought to achieve greater coverage of medical care to improve health equity in a period ranging from 2004 to 2012.[7]

The strategy privileged by the Mexican government to achieve universal coverage has been the extension of coverage of public insurance. This includes two approaches; the first one is to cover the uninsured population with purchasing power and is mainly directed to the urban population that does not participate in the formal economy. To this end, modifications were made to the General Health Law and the Social Security Law, leading to the creation of the Family Health Insurance in the mid-1990s.[8]

The second aspect was the creation of financial protection instruments granted through public insurance for the population without purchasing power and the creation of conditioned support programs. To this end, the General Health Law was amended in 2003 to create the Popular Health Insurance (SPS), while implementing intersectoral programs of conditioned support operated through focused standards. Both strategies of this second approach were framed in a model of integrated healthcare services. Derived from these initiatives, the Mexican government declared having reached universal coverage of public health insurance in 2012 at a meeting of the World Health Organization.[9,10]

These kind of strategies in the area of extension of insurance and social protection programs in health for populations without purchasing power have been implemented by several Latin American countries with segmented health systems similar to the Mexican health system. This is why we consider it is relevant to assess what has been done in Mexico and obtain lessons on what can be practical in policy analysis. In this sense, we decided to review a set of indicators of the production and financing of health services aimed at the universalization of medical care. The long-term strategic approach has been essentially to address the problems of equity, quality, access, and coverage of the National Health System, emphasizing its insurance strategies for low-income users.[11–13]

Taking into account all the elements raised previously, this manuscript presents results of governance indicators based on health reform. We highlight the strengths and weaknesses found in the Mexican experience of reform to looking for the main lessons learned that can help understand the other Latin American countries with similar reforms.

Methods

An evaluative research was developed with a retrospective design based on qualitative analysis. The changes, levels, trends, and effects of reform strategies on the governance of the public health system were the objects of analysis. The methodology of this study was based on a literature review including the analysis of documents such as official statistics and databases on financial resources and on in-depth interviews with key personnel in selected regions.

Study population and characteristics of selected regions

The population under analysis was the uninsured population in Mexico. The analysis was delimited for six regions of Mexico. The characteristics of the regions in Fig. 1 showed heterogeneity for the indicators of marginalization (per capita income and public services), public health insurance (infrastructure), epidemiological backwardness, political party in power at the regional level (noting that during the evaluation period, the political party of the right remained in power at the

Region	Total Population	Marginalization Index	Public Health Assurance Index	Epidemiological backwardness Index	Political party in the government	Indigenous Population Index
Region A	712,029	Low	Medium	Low	Left	Low
Region B	711,235	High	High	Medium	Center	Low
Region C	2,858,359	High	Medium	High	Center	High
Region D	7,844,830	Low	High	Low	Right	Low
Region E	3,967,889	High	Low	High	Center-Right	High
Region F	2,395,272	High	High	High	Center-Left	Medium

Fig. 1 – Characteristics of selected regions. Consejo Nacional de Población – Instituto Nacional de Estadística y Geografía, 2000–2005. Secretaría de Salud, Anuarios Estadísticos sobre Daños a la Salud, 1998–2005. Información para la Rendición de Cuentas, México, 2006–2013. Censo de Población 2010–2015.

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