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Emanuel Orozco Núñez

Armando Arredondo López

Anthropological view of the decentralization of the Mexican health system

ABSTRACT

OBJECTIVE: To analyze organizational, political and economic changes resulting from the decentralization of the health system for those in Mexico without health insurance.

METHODS: Three states, selected by considering the percentage of the population living in poverty, the political party in power and their stage of decentralization (the first was in 1984 and the second in 1997) were included. Interviews were conducted during 2007 with key informants from the state health care services, users of health care services, and community leaders. Data were analyzed from an anthropological and economic perspective.

RESULTS: Decentralization occurred in a heterogeneous way in each state, with responsibilities being transferred from federal to state level but without breaking the dependence on the central-federal level. The reforms driven from the federal level to create a scheme based on a principle of financial subsidies and democratization of the health system face challenges for their political and organizational consolidation.

CONCLUSIONS: The anthropological approach adopted in this analysis shows the relevance of considering organizational, economic and political factors as key components of the decentralization process.

DESCRIPTORS: Medical Anthropology. Health Care Reform. Decentralization. Health Systems.

Centro de Investigación en Sistemas de Salud. Dirección de Innovación en Sistemas y Servicios de Salud. Instituto Nacional de Salud Pública. México, DF, México

Correspondence:
Armando Arredondo López
Instituto Nacional de Salud Pública
Av. Universidad, 655
Col. Santa María Ahuacatitlán
Cuernavaca, Morelos
CP 62100 México
E-mail: armando.arredondo@insp.mx

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INTRODUCTION

The Mexican health care system is composed of three sub-sectors: social security, public services for the population without social security and the private sector. Because of political and structural factors,[a] when talking about the state health care systems in Mexico, it is the public services for the population without social security, provision for whom is organized by the state governments, which is being referred to. Provision of these services was delegated to the states – the decentralization process – between 1984 and 1997.

The decentralization of the health care systems meant, in theory, the transition from government body forms of organization, with a vertical chain of command, towards more horizontal and participative styles, following the principles of devolution, delegation and transferring functions, with the aim of improving the health care systems' performance.[5]

If decentralization has been studied from a political and public administration perspective,[13] it is also possible to analyze it from an anthropological perspective, taking its ramification on the exchange and influence of the distribution of resources as a starting point.[7] In particular, applied anthropology refers to anthropological investigation aimed at producing scientific knowledge in order to resolve problems which do not seek abstract discussion of a dimension of reality.[6,b]

Such analysis can be carried out in an environment of cultural study of the biomedical sector as a complex social organization which provides specialist health care services through institutions which may be either public or private.[10,c] This characterization assumes that curative health care is divided into sectors culturally and professionally, centered on the professional sector, representing doctors and the institutions in which they provide health care.[d] The relevance of studying the biomedical sector which provides public services lies in the fact that it represents the "organized social response" to the health care needs of the population who receive its services.

The objective of this study was to analyze organizational, political and economic changes resulting from the decentralization of the health care system for those in Mexico without social security.

METHODS

The investigation formed part of the investigative project "Health financing changes for decentralization: tools and strategies for health care reform in Mexico",[e] with the objective of investigating changes in the financing of the state health care systems after their decentralization. In this study, elements concerned with the political context and process are presented which are relevant to establishing that the conduct of this type of policy requires that organizational and cultural dimensions which favor better understanding of its limits and of locally developed capacities are considered in accomplishing its objectives.

The decentralization of the Mexican health care system was analyzed by defining dimensions applied to anthropological analysis of complex organizations: the forms and relationships which regulate the exchange of resources, as well as the characterization of processes and mechanisms in which individuals, groups and organizations participate in making decisions about topics which affect them. From this perspective, dimensions of economy and of power are considered. Finally, the relevance of analyzing cultural dimensions which influence these dynamics is established.[1]

The social problems analyzed aim to characterize the distributive and political effects, linked by informants, key to conducting the decentralization of the health care system in three Mexican states. From the point of view of the organization, developments in management for implementing the decentralization and economically identify changes in the allocation and distribution of resources. The analysis proposes to document local arrangements, under particular conditions, favoring or limiting the state's decentralization objectives. Elements of analysis of bureaucracies, in this case, in the tertiary sector, are also taken up. This focus aims to document organizational, governmental and business dynamics form a cultural perspective, in which information and its interpretation play a central role.[11]

Given that the central focus of the decentralization of the Mexican health care system was to improve inequalities in federal financing of the state health systems, principles and values related to the distributive practices of decentralization are examined. The question of exchange is related to the way in which the interviewees interpreted the relationship between levels of government, in the areas of autonomy, redistribution and maximization of resources.

Social anthropology techniques, such as field work in health care offices and clinics, observations, interviews,

[a] Martínez Valle A. La dimensión política de los procesos de reforma en el sector salud. In: Frenk J, editor. El observatorio de la salud. México (DF): Fundación Mexicana para la Salud; 1997. p.359-377.
[b] Palerm A. Teoría etnológica. Querétaro de Arteaga: Universidad Autónoma de Querétaro; 1987.
[c] Frenk J. La salud de la población: hacia una nueva salud pública. México (DF): Fondo de Cultura Económica/CONACyT; 1993.
[d] Fitzpatrick R, organizador. La enfermedad como experiencia. México (DF): Fondo de Cultura Económica; 1990.
[e] Project carried out in the Instituto Nacional de Salud Publica with financial supported by International Development Research Centre, Canadá.

Table. Characteristics of the participants by state, México, 2007.

State	Type of informant							
	Department of Health	Planning Officials	Administrative staff	Service provider	Policy makers	NGO leaders	Service users	Total
Baja California Sur	1	5	5	5	2	2	10	30
Colima	1	4	4	4	2	2	10	27
Jalisco	1	6	6	5	2	3	10	33
Total	3	15	15	14	6	7	30	90

NGO: Non-governmental organization

field diary and systemizing the information from a cultural perspective were employed.[9] The field work took place in Baja California Sur, Colima and Jalisco. In each state, semi-structured interviews were carried out, consent having been previously sought from participants, with state employees in the health care services, with doctors in rural and urban clinics, with political representatives, with leaders of civic groups and with service users at the clinics visited. The interviews followed a guideline of 30 questions. The profiles and number of interviewees is shown in the Table. The total number of people interviewed was 90.

The project was approved by the Committee for Ethics, Biosecurity and Research of the Instituto Nacional de Salud Pública, code PI-100022, in 2005. The interviews were recorded, with the participants consent and were digitally transcribed. The mean length of interview was 40 minutes, shorter in the case of the service users. These data were organized for analysis using the computer program ATLAS-Ti (The Knowledge Workbench, Scientific Software Development, Berlin, Germany). This program allows data to be spilt into segments of text and grouped for analysis using *ex profeso* codes. This has the advantage that grouping the segments of text thematically preserves the information of the interviewee to whom it corresponds. The main categories used for coding the data were: Notions of decentralization, Transfer of functions, Sources of finance, Changes in allocation mechanisms, Management of resources, Spending mechanisms, Political processes, Political agreements, Participation in decision making and Local autonomy.

RESULTS

The data is presented in three sections related to organizational. Economic and political dynamics related to the key informants for implementing the decentralization of the health care system in the states studied.

The organizational dimension of the decentralization

The data analyzed is related to the transfer of responsibilities, the modification of the centralization and the development of managerial capacities resulting in the transfer of resources and responsibilities from federal government to state governments. In this regard, references were found to the nature of the transfers delegated and the structural modifications aimed at facilitating such transfers. An employee from Baja California Sur, who had also been a legislator, stated that these transfers improved local decision making processes:

"… the functions of the federal Department of Health have been delegated to the state. Before, the federal Department of Health decided where and according to what criteria health care units would be constructed. Now those decisions are made here..."

Another principle of decentralization which was explored refers to the modification of a centralized scheme at the federal level, to a decentralized one at state level, which shows better links between federal, state and municipal level. This link was expressed by an employee in Colima, from the planning area, as a result of better intergovernmental links:

"... There is closer communication between the municipal authority and the state health care services authorities. The communication between federation and state is much quicker ..."

It was significant that the majority of the interviewees showed various degrees of lack of awareness of the normative and technical criteria of the decentralization, above all in Baja California Sur and Colima. However, experiences of developing directive capacities were documented as a strategic factor of the local system in order to achieve greater autonomy in managing resources and making decisions. An employee in a health district in Jalisco connected aspects favorable to decentralization to the organization of the health care system on a local level:

"... I think that the legal concept of decentralization opens doors for us as we are defined as a decentralized public organization. This gives us more autonomy in managing resources, more legal opportunities in commitments and more operational opportunities…"

The economic dimension of decentralization

Given that one of the explicit objectives of the decentralization of health care was to increase financing,[f] in this section, local financial capacities, the state capacity to manage resources and the mechanisms to maximize resources are examined.

It was found that the majority of the interviewees identified three sources of financing for health care services: resources provided at a federal level, at a state level and from those who had consultations. Only in Jalisco were resources from municipal government mentioned. In this state, it was established that decentralization would increase the financial participation of state and municipal governments, for which purpose greater capacities of management and administration of resources were developed, as expressed by a high level state decision maker:

"... changes at the level of financing were made, such as the state getting the opportunity to negotiate an additional budget. Also, management agreements can be made with civic organizations interested in participating in health care. And we have the opportunity to open other doors to federal dependence..."

Once the difference in terms of state capacity for the management of resources had been established, it was investigated whether these were connected to institutional management of criteria and technical mechanisms. In this regard, we found differential management of such criteria. Various statements hinted that the criteria used needed to refine their scoped as regards the management and use of resources, suggesting that the stalemate between allocating resources and meeting needs required further rationalization to improve management. A doctor in Colima, with long experience of working in state health care services commented:

"... For years they have tried to perfect the budget for the program and they have never managed it. The allocation criteria continue to be subjective and much at the discretion of a very small group of people. I believe these criteria need to be rethought ..."

The reference data in the state for combatting the scarcity of resources favors the identification of maximization strategies related to savings and diversification in the sources of financing. In the first case, distinct mechanisms of saving in order to widen spending on resources are referred to, applying criteria of priority, such as those expressed by a doctor in Baja California Sur, linked to state finances:

"… we don't have the capacity that they might have in Guadalajara, México or Monterrey. I am thinking of approaching a counterpart in Guadalajara or in Monterrey to ask them to send me 3,000 more leaflets, and I'll send them the money, it would be cheaper…"

The diversification in sources of financing at that levels includes the need to request contributions from citizens for medical appointments and care in hospitals. On the subject of these so-called 'recovery fees', interviewees from health care services in all three states expressed favorable opinions. On the other hand, community leaders and service users stated that the charges, when combined with other costs, make it difficult to visit the clinics. A mother of a family in Baja California Sur expressed her unease with charging for medical attention:

"… I do not agree with charging. I work in a bar and travel from San Lucas to San José and sometimes I can't come. Here they tell us to come Monday, Tuesday, Wednesday and Thursday. When it is Friday they charge double; I just had to pay, they charged me …"

Maximizing resources is based on the idea that increasing the financial base is necessary to meet the growing needs of the populations who seek health care in the state health care services. However, evidence was collected showing that a proportion of the resources goes towards resolving the systems' own needs related to human resources and infrastructure, in which it is highlighted that investment in human resources may affect the budget, as expressed by a decision maker in Colima:

"… The problem we have is that we support a large staff which absorbs a significant amount of the budget and limits operational spending. This makes life difficult for the administration, who have to scrimp and save to be able to guarantee the employees their wages; and this is basically supported by the state budget…"

The political dimension of decentralization

The decentralization of the health system aimed to change the relationship between the states and the federal level in Mexico, to promote greater autonomy in the state governments for managing their health care systems.[f] According to several of the interviewees, this autonomy was contingent on the state government's management of public policies, on local adaptation to legal frameworks and to the various levels of control of the management and use of resources. The documentation of these dimensions enables the characterization of local arrangements which show themselves to have influenced a differentiated decentralization in the states' health care.

When the changes in relation to the state and federal level after centralization were investigated, it was

[f] Arredondo A, Parada I, Orozco E, García E, Atrisco R, Allende T, et al. El financiamiento a partir de la descentralización del sistema de salud en México: Cambios, tendencias y evidencias, 1990-2000. México (DF): Instituto Nacional de Salud Pública; 2002.

established that, regardless of state capacities, the federal level should guarantee resources for health care for the vulnerable population, as referred to by a Councilman from Colima:

"… It is an obligation of the State to provide health care and citizen contributions should not exist because people have needs, people have many problems to resolve. The State should absorb the charges…"

From the perspective of the personnel of the state health care systems, the federal and state levels have the capacity to provide health care services based on designing structural policies to guarantee this provision. It is relevant that this capacity has been referred to as a result of political agreements, in which the diverse governmental representatives take responsibility for guaranteeing the provision of health care services, as this decision maker from Baja California Sur states:

"… I listen to the President and the Governor talking about the projects which are going well. In terms of health care, in this government we are starting to promote the new Seguro Popular – national insurance, we also approve of this program, which the President is leading. Somehow, these programs are very transparent and not politicized, but far-reaching…"

From the perspective of diverse decision makers, the implementation of decentralization policies in the states requires the management of their regulatory frameworks. This management requires technical capacities, whose management was generally limited, although these capacities were referred to as central components in achieving the objectives of the health care decentralization policy. An analyst from Jalisco stated as follows that greater availability of resources requires specific criteria for their use:

"… What I think is that the opportunity to have access to additional budgets should not be subject to the contribution of the state, but should be perfectly established in a distribution formula: if there is an additional budget it is distributed according to this formula and the state applies it where the real health care priorities lie…"

One of the most important findings was that the expansion of health care services was also referred to as part of a governmental project. In this way, the allocation of extraordinary items was documented in Colima in a parallel way to the electoral process. The involvement of those in government was referred to, as shown in the statement from this decision maker:

"… This year, in a very important move, the State Government opened the way for us to cover the charges of the Seguro Popular for the poorest in the population. There are ten items which establish the rules of the operation. The state government covers levels one and two, who, at the end of the day, are the population which goes for membership…"

This last point suggests that analysis of public policies needs to include elements of the political context in its local implementation, given the reference to situations of political plurality which may affect diverse reach of governmental policies. This was expressed in the following way by a Councilman from Colima:

"... Unfortunately there are political problems. Here the state is 'priísta' (the Partido Revolucionario Institucional) and the municipality is 'panista' (the Partido Acción Nacional). There shouldn't be, but there are attacks. The same in the municipalities. I have experienced two administrations, one panista and one priísta and I've seen an enormous difference. The panistas won and I believe they are going to discriminate and marginalize..."

DISCUSSION

This article shows that the decentralization of the health care system involves significant organizational, economic and political dimensions in order to achieve the development of forms of autonomy at the local level.[4] Applying an anthropological focus encourages the documentation of economic dynamics of maximizing resources, proving that when these are scarce, the tendency is to take advantage of them for various ends.[7] It was favorable that the economic processes analyzed were expressed in a heterogeneous manner, suggesting that they correspond to the economic dynamics of complex organizations.[12]

This study aims to become one of the social and political analyses which have characterized the effects of the transfer of public policies in the development of governmental capacity to improve the distribution of resources as a consequence of decentralization.[2] Given that the decentralization of the health care system in Mexico assumed that changes in the financial transfers destined to finance the production of public health care services, analysis of the form in which these economic processes are expressed is relevant in the discourse of key informants.

The exercise sought to show that the implementation of the decentralization of the health care system has had heterogeneous effects, varying from state to state and according to the characteristics of the key informants. The relevance of analyzing them anthropologically was to establish the validity of statements on the effects of this policy in various Latin American countries on changes in the decision making processes and the participative mechanisms. In the case of Brazil, decentralization has raised implications from

a social perspective, proposing that this implies a revision of the governmental action aimed at greater democratization in the decision making processes to improve the impact of social policies.[3]

In terms of the governmental dynamic between levels of government, the relevance of establishing a debate on federalism compared with state units has been raised, taking into account that both forms of organization have implications on the forms of distribution of political authority between levels of government in terms of autonomy or delegation of power.[3]

Another level of analysis refers to the implications of coordination and autonomy of decentralization. In this respect, it suggested that the federal states tend to face greater problems of governmental efficiency in terms of social costs due to the dispersion of political authority and the internal concentration of collective decision, a topic which encompasses highly complex dimensions of coordination and autonomy.[3,5]

In the case of Mexico, although there is vast experience in the study of the managing of sectorial public policy, further analysis from a sociological focus is needed to analyze the effects of decentralization given the prevalent governmental centralism in formulating health care policy.[g]

CONCLUSIONS

Decentralization is a dynamic agent for providing the organization of health care systems with greater efficiency,[8] generating opportunities for the states to be autonomous.

The incorporation of an anthropological perspective was useful in approaching the analysis of the health care systems as complex organizations of a professional and bureaucratic character. This approach to the problem of investigating, taking its staring point as applied anthropological analysis[9] and the investigation of health care system,[h] had great analytical potential, as both perspectives establish the importance of carrying out strategic investigation in a systematic way to modify the situation of the object studied.

In conclusion, within the limits of the sample and the representativeness of the analysis conducted, it is considered that this type of exercise represent significant contributions on the part of the social sciences to the study of health care systems and their social practices.

[g] Merino G. Descentralización del sistema de salud en el contexto del federalismo. In: Knaul F, Nigenda G, editors. Caleidoscopio de la salud. México (DF): Fundación Mexicana para la Salud; 2003. p.195-207.
[h] Mills A, Gonzalez Block M. Strengthening health systems: the role and promise of policy and systems research. Geneva: Alliance for Health Policy and Systems Research; 2004.

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