Quality governance in a pluralistic health system: Mexican experience and challenges

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The leading health policies in Mexico focus on reaching universal health coverage (UHC), with the aims of facilitating access, providing financial protection, and increasing the quality of care. These policies have been in place for more than 15 years and are in line with the objectives of the Sustainable Development Goals (SDGs). However, UHC alone is not enough to achieve and maintain the SDGs if the health system does not provide high-quality technical and interpersonal care.[1] The framework of the *The Lancet Global Health* Commission on high-quality health systems in the SDG era suggests that successful governance for quality of care needs to focus on the foundations of health systems, processes of care (competent care and positive user experience), and impacts (health, confidence in the system, and economic benefit).[2]

In Mexico, political will and the non-contributory health-care insurance Seguro Popular programme have led to substantial gains in coverage. As of 2016, 92·3% of the population has public health-care insurance,[3] with the remaining 7·7% including those living in hard-to-reach areas with irregular access to care. Furthermore, 8% of the population is covered by private health-care insurance.[4] However, assessing health outcomes, economic benefits, and confidence in the system reveals that improvements are needed to attain a high-quality health system. Multiple indicators—such as mortality due to myocardial infarction and stroke, avoidable hospital admissions, and amputations in diabetic patients, among others—remain above Organisation for Economic Co-operation and Development average.[4] Out-of-pocket expenditures are high, constituting 45% of the total health expenditure.[4] Long waiting times and inadequate supply of health-care services contribute to high demand for private health care and high out-of-pocket expenditures.[4-6] 82% of the population believe that the health system requires fundamental change,[6] further indicating a lack of confidence in the health system to meet their needs.

This Comment analyses the influence of the pluralistic characteristics of Mexico's health system on the governance of quality of care, pinpoints potential barriers that the Ministry of Health of Mexico should overcome to strengthen governance to assure high quality of care, and provides recommendations to set the future directions of quality of care governance.

Mexico is an upper-middle-income country with a complex health-care system. Two circumstances have contributed to this context: the segmentation of health-care provision and the decentralisation of its governance. Employment status (formal or informal) defined the creation of different health institutions and types of public health-care insurance. Currently, social health insurance covers employees working in the formal labour market and their families. The Mexican Institute of Social Security (IMSS) provides care to 62 million affiliates and the Institute of Social Security of State Workers (ISSSTE) provides care to 12·9 million. Oil, navy, and army workers have their specific social security institutions. Seguro Popular covers 54 million individuals without social security.[7] Furthermore, there is a substantial supply of individual and corporate private health-care providers; half of available examining rooms and hospital beds in the country are private. Decentralisation has shaped health system governance. Mexico is a federal republic and, since decentralisation in the 1980s and 1990s, each of its 32 states operates autonomously, with distinct governmental organisation. The Ministry of Health is responsible for stewardship, policy generation, public health programmes, and health information at the national level. The Ministry of Health is decentralised into 32 local health secretariats, each with different organisational structures and processes, providing health care to Seguro Popular affiliates.

At a national level, the Ministry of Health has been working to improve the governance of quality of care, consolidate it as a core value in the culture of public and private health-care institutions, and enhance its importance to improve health-care processes and impacts. Substantial breakthroughs attest to the progress of quality of care policies. Some examples are the inclusion of quality assurance in the General Health Law (2003), the National Crusade for the Quality of Health Services (2001–06), the Accreditation and Certification of Health Facilities (2004), and the strategy to build an integrated quality of care system named SiCalidad (2007–12).

Panel: **Barriers and future directions for strengthening quality of care governance**

Barriers

- Governance and leadership of quality of care are fragmented, mirroring the situation of the Mexican health system
- Inadequate organisational structure to manage quality of care activities
- Scarcity of human resources and insufficient training of health professionals and executive and managerial staff for quality of care activities
- Scarcity of financial resources allocated to quality of care activities
- Heterogeneous mechanisms for quality of care assessment among health institutions
- Results from quality of care assessments are not fully available to health professionals and the public
- Patients are not actively engaged in quality of care activities
- Ongoing quality of care improvement programmes are heterogeneous, with different strategies and targets among health institutions

Future directions

- Reinforcing hierarchy for quality of care governance by defining rules and allocating resources and responsibilities, with a top-down control; the centralised power of the Ministry of Health should be secured to determine quality of care policies and lead governance
- Reinforcing market perspective through purchasing, regulation, and creation of incentives for quality of care
- Reinforcing network perspective by establishing cross-institutional quality of care values, objectives, and information and learning systems
- Investments should be made to reduce shortages of human resources for quality of care
- A culture for quality of care must be built and continuously reinforced by training of health-care leaders and professionals
- Purposeful quality of care assessment for accountability and guiding quality of care improvements; a quality of care information system should be in place and shared by all health-care institutions
- Results from quality of care assessments of all public and private providers should be public
- Strategies for patient empowerment and their active involvement to demand better quality and to guide the development of improvement strategies, such as the Ministry of Heath's so-called Citizen Endorsements, should be incorporated by all health-care institutions

Since 2012, the Ministry of Health has run the National Strategy for Quality Consolidation in Health-care Facilities and Services.[8] This strategy comprises the following: quality and patient safety, innovation and continuous improvement, risk management, health-care facility accreditation, health regulation, and health education.

In 2017, the national high-quality health system Commission of Mexico, instituted alongside *The Lancet Global Health*'s Commission, did a survey of 320 quality of care leaders from local health secretariats, IMSS, and ISSSTE at state, hospital, and primary care clinic levels to identify barriers that prevent quality of care policies from leading to meaningful improvement in health system quality, and recommend future directions to strengthen quality of care governance. High-level findings are summarised in the panel and discussed in the following paragraphs.

Mexican health institutions share common barriers to quality of care activities. Currently, governance of quality of care is fragmented, mirroring the situation of the Mexican health system. Therefore, health institutions have wide variability in their agendas and approaches to quality of care foundations, processes, and impacts. The Ministry of Health's governance on quality of care is not widely recognised or followed; uptake of federal quality of care programmes is weak at social security institutions and the private sector.

Not all health institutions have an adequate organisational structure to manage quality of care activities. The Ministry of Health alone has a clear normative area of quality of care policies and management at federal and local health secretariat levels. The local health secretariat jurisdictions and hospitals have quality of care managers. At social security institutions, only tertiary care hospitals have a quality of care manager. At secondary care hospitals and primary care clinics, local authorities are responsible for the quality of care management.

There is scarcity of human resources and insufficient training of health professionals and executive and managerial staff for quality of care activities. At health facilities, all institutions lack exclusive permanent staff for quality of care assessments and improvement. Health personnel participate in quality of care activities on a voluntary basis, beyond their daily workload. Health professionals and executive and managerial staff are ill prepared for quality of care activities. The scarcity of human capacity contributes to insufficient learning of quality-related assessment and improvement activities. The shortage of financial resources allocated to quality of care activities reduces the scope and potential impact of quality of care interventions.

Performance evaluation of health professionals and services is standard practice, but its mechanisms are heterogeneous. The health system has more than 1000 indicators, of which 44·8% are related to quality of care. The Ministry of Health indicators are comprehensive, in line with the SDGs, and include *The Lancet Global Health* Commission's framework domains and patient-reported indicators. However, the consistent measurement, analysis, and reporting of such indicators is not mandatory for health institutions. Only local health secretariat facilities apply these indicators

regularly. Social security institutions and private providers report them sporadically; instead, they use in-house performance indicators. The wide variability of quality of care indicators affects the efficiency of data collection and interpretation of the findings, thus undermining quality of care assessment across the whole health system.[9] Particularly, homogeneous indicators are crucial for the benchmarking of health institutions and facilities.

Results from quality of care evaluations are not fully available to health professionals and the public. Most data travel from bottom to top levels only, and the results from indicators other than the health-care quality indicators system of the Ministry of Health are not public. Although assessment of patients' satisfaction and complaints is institutionalised, this mechanism does not ensure patients' active engagement in quality of care activities. Ongoing quality of care improvement programmes are heterogeneous, with different strategies and targets among health institutions.

Quality of care governance can be enhanced in four aspects: hierarchy, market, network, and capacity building. Hierarchy means the ability to define rules and allocate resources and responsibilities with top-down control.[10] To guarantee quality of care in a pluralistic, decentralised health system, it is crucial to secure the centralised power of the Ministry of Health to determine quality of care policies and lead governance. Currently, the Ministry of Health has the legal and normative responsibility to do this, and its governance should be implemented through mandatory mechanisms.

Market emphasises purchasing, regulation, and creation of incentives.[10] The Ministry of Health has the conditions to reinforce the market perspective. Seguro Popular split purchasing from provision, and it currently funds health-care services for its affiliates. This circumstance can contribute to reinforcing regulations and creating incentives to improve quality and accountability that should be aligned with policies. For instance, purchasing of health care can be tied to the fulfilment of national quality standards.

The network perspective means building cross-institutional quality of care values, objectives, and information and learning systems.[10,11] Policy dialogue can generate agreement on quality of care objectives across institutions to implement efficient mechanisms to disseminate and promote adoption of federal Ministry of Health quality of care programmes. Joint strategic planning can set the groundwork to articulate the efforts of the Ministry of Health with the other health institutions. These efforts might include standardising the set of quality of care indicators, building up a national quality of care information system, and creating the conditions to share data and results of evaluations across institutions.

Capacity building should serve to create an enabling environment for quality of care governance, evaluation, and improvement activities at local and state levels. A culture focused on quality of care must be motivated and continuously reinforced. Training of health-care leaders and professionals and reducing the shortages of human resources must be a priority to strengthen the foundations of quality of care. Training should focus on technical and interpersonal aspects of quality to increase the capacity of clinicians to identify and fulfil patient expectations and priorities. It is essential to assess users' experiences and expectations to identify areas of opportunity, as well as empowering and actively involving them to demand better quality and to guide improvement strategies. Policies, programmes, interventions, and assessments should be public and comprehensive for health personnel and the community that Mexican institutions serve.

Strengthening quality of care governance is a crucial step towards a high-quality health system; these directions offer promise for more cohesive and systematic attention to quality of care in the context of a pluralistic and decentralised health-care system.

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We declare no competing interests.

1 Kruk ME, Larson E, Twum-Danso NA. Time for a quality revolution in global health. *Lancet Glob Health* 2016; **4:** e594–96.

2 Kruk ME, Gage AD, Arsenault C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health* 2018; published online Sept 5. http://dx.doi.org/10.1016/S2214-109X(18)30386-3.

3 Organisation for Economic Co-operation and Development. Health at a glance 2017: OECD Indicators. 2017. https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en#page1 (accessed Aug 8, 2018).

4 Organisation for Economic Co-operation and Development. OECD reviews of health care systems: Mexico 2016. 2016. https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-mexico-2016_9789264230491-en#page1 (accessed Aug 8, 2018).

5 Pérez-Cuevas R, Doubova SV, Wirtz V, et al. Effects of the expansion of doctors' offices adjacent to private pharmacies in Mexico: secondary data analysis of a national survey. *BMJ Open* 2014; **4:** e004669.

6 Pérez-Cuevas R, Guanais FC, Doubova SV, et al. Understanding public perception of the need for major change in Latin American healthcare systems. *Health Policy Plan* 2017; **32:** 816–24.

7 Gobierno de los Estados Unidos Mexicanos. Cuarto informe de Gobierno 2015–2016: anexo estadístico. 2016. http://www.presidencia.gob.mx/cuartoinforme/ (accessed Aug 8, 2018).

8 Dirección General de Calidad y Educación en Salud. Programa de acción específico: estrategia nacional para la consolidación de la calidad en los establecimientos y servicios de atención médica—programa sectorial de salud 2013–2018. 2013. https://www.gob.mx/cms/uploads/attachment/file/31025/PAE_2013_2018_DGCES.pdf (accessed Aug 8, 2018).

9 Blumenthal D, Malphrus E, McGinnis JM. Committee on core metrics for better health at lower cost. In: Institute of Medicine. Vital signs: core metrics for health and health care progress. Washington, DC: The National Academies Press, 2015.

10 Smith PC, Anell A, Busse R, et al. Leadership, and governance in seven developed health systems. *Health Policy* 2012; **106:** 37–49.

11 Ferlie E, Fitzgerald L, Mcgivern G, et al. Public policy networks and 'wicked problems': a nascent solution? *Public Administr* 2011; **89:** 307–24.