

Health Reform in Mexico City, 2000-2006

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Abstract

With the goal of fully guaranteeing the constitutional right to health protection, Mexico City's leftist administration (2000-2006) undertook a reform to provide health services to people without insurance. The reform had four components: free medicine and health services; the introduction of a new service model (MAS); the strengthening, expansion, and improvement of services, and legislation to ensure that the city government become guarantor of this constitutional right. The reform resulted in 95% of eligible families being enrolled in free care; expansion of health care infrastructure with the construction of five new health care centers and a 1/3 increase in the number of public hospital beds in impoverished and disadvantaged areas; increased access to and use of health services particularly by the poor and for expensive interventions; and the legal guarantee of the continuity of this policy. The implementation of this new policy was made possible through an 80% budget increase, improvements in efficiency, and a successful fight against corruption. The health impact of the reform was seen in decline of mortality rates in all age groups between 1997 and 2005 (22% for child mortality, 11% for economically active age groups, and 7.9% for re-

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tired age groups) and by a 16% decline in AIDS related mortality between 2000 and 2005. This reform contrasts with the health care reform promoted by the right wing Federal government in the rest of the country; the latter was based on voluntary health insurance, cost-sharing by families, access to a limited package of services, and gradual enrollment of the population not covered by the Social Security System.

Key words: Mexico City, Right to Health, Progressive Health System Reform, Free Public Services, Universal Access.

The electoral victory of a left and progressive coalition in Mexico City, first in 1997 and then again in 2000, opened the door to both immense opportunities and challenges in the field of social policy. Opportunities arose, because social well-being became the government's top priority; challenges arose from the need to overcome the legacy of years of neoliberal and right-wing thought in social policy and to rebuild after a long period of institutional deterioration.

The policies of the left in contemporary Mexico are founded on the idea that the universality of social rights is central to the creation of an egalitarian society. (Bobbio, 1998) These rights were accepted early on in Mexico as part of the social revolution during the first years of the 20th Century. Despite the fact that these rights have always been partially fulfilled, active efforts to suppress them started only in 1983 with the imposition of the neoliberal project. From that point on, Mexico has seen a long process of neoliberal structural adjustment and change in social security and health.

Social Policy, Framework of Health Policy

Social policies are based on "world views" that emerge from a set of values and principles. They are not limited to the creation of rules and regula-

tion of the behavior of economic agents and social actors. Social policy, as a particular field of public policy, derives from differing visions of how to create well-being and satisfy social needs. These differing social visions are expressed through specific institutional arrangements and specific actions. As a result social policy is not neutral; it favors the interests of some groups while curbing those of others. (Navarro, 1997)

The Plan of the Mexico City Government, headed by the Governor Andrés Manuel López Obrador (2000-2006), synthesized the relative importance given to different social groups in the precept “For the Wellbeing of All; First, the Poor.” In other words, a decision had been made that the main purpose of the Plan was to further the general interests of a society in which the majority of people were poor. This was done instead of prioritizing those small powerful groups that were daily growing richer as a result of their privileged position. This, then, was the proposal and policy of the City government: to decrease the polarization and resultant fragmentation of Mexican society between the poor majority¹ and a minority living in luxury; in other words, government power was fundamentally redirected so as to decrease the shameful inequality among citizens.

It should be pointed out that the recognition of social rights is based on the idea that all citizens, by virtue of the very fact that they are citizens, have a right to the basic necessities of a decent life in conformity with prevailing social conditions. As a consequence all rights are universal. Society’s duty is to guarantee the satisfaction of these basic necessities using public means and through the actions of the State. This conception should be distinguished from that of human rights, in that it makes the State responsible for guaranteeing a right —“the satisfaction of basic needs”— for all citizens and not just for those who would be unable to attain them by other means. This distinction points to one of the fundamental differences between a *universal* social policy that benefits all citizens and a social policy that is selective and targeted to specific groups; such targeted policies are typical of right-wing and liberal projects. (George y Wilding, 1994)

¹Boltvinik calculates that in 2000, 5.6 million people in Mexico City were poor, representing 65% of the city’s population. (Boltvinik, 2000)

The concept of collective social rights is also important to a Left project against inequality because it implies policies which redistribute resources through freely available public services in order to make basic living standards more equal. This contrasts with the neoliberal opposition to redistribution by the State, which is considered a violation of market laws. Neoliberal analysis emphasizes inequalities between individuals rather than between classes or large social groups, leading it to adopt targeted policies for certain “vulnerable” groups or individuals. (George y Wilding, 1994)

A policy based on social rights assigns public institutions a central role as guarantor and producer of the services required to satisfy specified needs. The construction of new public institutions or of new institutional arrangements allows the materialization of values and social conceptions in such a way that these institutions, in turn, are able to create and consolidate new values and social norms. (Rothstein, 1994)

The strengthening and authority of public institutions became especially important in the development of Mexico City’s plan because it ran counter to the right-wing Federal government’s privatization initiative. The reconstruction of public institutions posed a major challenge for the City; it was essential to develop an infrastructure that could adequately respond to citizens’ demands. Existing institutions suffered from deep-rooted problems arising not just from long periods of neglect, but also from their domination by special interests not concerned with the general welfare; these posed fundamental roadblocks to creating new social arrangements in an institutional culture built on patronage. Another aspect of this problem was the misuse of public resources through political favors as a tool of social and corporate control.

Other basic factors of the new social policy in Mexico City were the large number of people who might be impacted by the program, the need to reduce bureaucratic expenses and its localization to well defined geographical areas. By extending the plan—and the budgetary resources—to very specific communities the possibility arose for a new model of management accountability and transparency; this happened with the creation of neighborhood committees. It also established the framework

for the program's initial focus on meeting unsatisfied needs ("degrees of marginalization") within the socio-territorial space. This approach has been shown to be more successful than approaches which that are focused on individuals and more similar in efficacy to programs based on universal social benefits. (Mkandawire, 2005) Universalization and territorial decentralization were powerful tools in fighting bureaucratic abuse of power and the patronage system. When a right is for everyone or when a program has explicit criteria of inclusion/exclusion, the roots of favoritism vanish altogether.

The Right to Health and Challenges to the Mexico City Government Plan

The right to health is one of the least controversial of social rights. It directly affects the preservation of life and of the individual's very existence. This confers upon it an unquestionable ethical authority. It has even been argued that health is a basic and transhistorical human need. The lack of health produces serious damage and suffering to the individual, impeding the development of his or her abilities and full participation in society. (Doyal y Gough, 1991)

This right has been part of the Mexican Constitution since 1983. However, for the many Mexican citizens who lack social security, it remains an unfulfilled promise. In the framework of a universal social policy and with a commitment to respect and protect equally the lives of all human beings, the Mexico City government undertook to make the right to health protection a reality. It did this in its role as guarantor of the general or collective interest of the City's citizens.

A barrier to achieving this objective has been—and remains—the complex and centralized/decentralized structure of Mexican social welfare institutions. In this fragmented system, decentralized State institutions care for people lacking employment-based social security, while a centralized government institution cares for people who are enrolled in one of the public (employment-based) social security programs.² In addition, the ability of these two large groups to demand access to care is different. Article 123 in the Constitution³ states that it is an obligation of the employer to provide

health services to employees and their families through the Social Security Institutes. In contrast, Article 4 does not state who is supposed to guarantee this right to the population lacking employment-based social security.

Health services for the uninsured population in Mexico City were hastily decentralized in 1997 in anticipation of the left's electoral victory. They became the responsibility of the Secretary of Social Development. This institutional arrangement revealed the strong influence of neoliberal thinking which favors the unification of all social programs in a single ministry with minimal and narrowly focused programs for only those people who can demonstrate that they are truly needy.

The first institutional health reform of the democratic government was to create the Mexico City Health Department (Secretaría de Salud, SSDF) in 1999. Since primary and secondary education had not yet been decentralized, the SSDF became the largest social service department in terms of infrastructure, employees, and operative capacity. This institutional strength explains the role that the SSDF later assumed in terms of the universal citizen pension.

There were other restrictions on the city government's ability to formulate and execute social policy; the City had only local authority and lacked the powers of a federal agency. The City's limited ability to tax and the prohibition on borrowing for social programs both established restrictions on how much could be spent on social programs. This also required that all resources be used wisely.

Making the right to health universal involved several different components, each designed to address the primary goals of improving health conditions and decreasing the inequalities of mortality and morbidity between different social and geographical groups in the City. One component was to guarantee timely access to necessary treatment

² There are two such large institutes: one for workers in the private sector (Mexican Social Security Institute, *Instituto Mexicano del Seguro Social*) and another for workers in the public sector (Institute of Social Security and Services for Public Employees, *Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado*).

³ See Article 123 A-XXIX and B-XI of the Mexican Constitution.

and simultaneously decrease inequality in health care access. Another challenge was to improve sanitary conditions in the city through a series of activities at a community level. In order to accomplish both of these goals, the system of public health services had to be strengthened and supported by a financing mechanism that was stable, adequate, equitable, and reflective of values of social solidarity. In practical terms, providing universal coverage of health care services in Mexico City meant giving medical attention to the uninsured population—approximately 45 percent of families—who had been left out by the post-revolutionary State's historical strategy of providing health services through employment-based social security. (Laurell, 1996)

Analysis of the barriers to treatment for the uninsured revealed that the cost of medicines and services was the principal health care access problem. (Health Department, 2000-2001) A striking disjunction also existed between the health needs of the population on the one hand and the types and locations of services on the other. The types of services reflected the needs of people in the 1970's and 1980's. For instance, there were 11 pediatric hospitals at a time when birth rates were decreasing. In contrast, internal medicine services were lacking despite rising rates of chronic and degenerative illness. Moreover, existing services reflected a long history of neglect which was apparent in their physical deterioration and institutional demoralization. Public health had survived, but under conditions that hindered the accomplishment of its mission to provide its users with timely and high-quality care.

The Program of Free Medicines and Medical Services (PFMMS)

To address economic barriers to health care access the *Free Medicines and Medical Services Program (Programa de Servicios Médicos y Medicamentos Gratuito, PFMMS)* was developed for uninsured residents in Mexico City. This program formed the axis for all the actions of Mexico City Health Department. All uninsured inhabitants of the city were eligible to register in the PFMMS as long as they were not receiving health care coverage

through social security. The foundation of this program was the strengthening and transformation of the public health infrastructure which would make this program a reality.

The Mexico City health program took effect in July 2001 (Official Gazette of Mexico City, *Gaceta Oficial del Distrito Federal*, 2001). This was two and a half years before the initiation (in January of 2004) of the federal program known as *Seguro Popular*⁵ (System of Social Health Protection (SPSS). Mexico City's health program—different in both concept and practice—was developed as an alternative to the federal program and it has proven to be a viable alternative. The differences between these two policies are indicative of the essential components of the two different national agendas facing Mexico today.

Mexico City's health project was designed to respond to existing health needs and to meet them by strengthening public institutions and removing economic barriers to timely access to necessary services. The program's principle for promoting equity is that people with similar health needs should receive similar services. Following this principle, services are financed through taxation and not by asking families or individuals to pay any sort of fee.

In contrast, the federal project has as its model a health care market based on free competition; it created a health insurance program to finance and purchase health services. (González Pier, 2007) It limits the right to health by restricting access in two ways: first, insurance must be purchased⁶ and secondly, coverage is limited to a predetermined package of services which are established on the basis of a cost-benefit analysis and only a limited number of interventions considered catastrophically expensive (*gasto catastrófico*). It is worth noting that those services not covered by the insurance program are to be paid for by the patients. In this system equity means payment of fees according to income level. This system has worsened health care access since it marginalizes those individual who

⁵For a detailed analysis of *Seguro Popular*, see Laurell, 2007.

⁶Only the poorest 20% of the population is exempted from this requirement.

cannot pay for insurance and whose only alternative for accessing services is to pay users fees. Access is further restricted because the national program can only register 14.3 percent of the uninsured each year. Moreover, it is up to State governments to come up with the money to pay their insurance premiums for the uninsured.

In contrast, the *Program of Free Medicines and Medical Services* (Health Department, 2001-2) offers all of available services free of charge including all medicines on the program's formulary. Enrolling in the program is a simple procedure and can be done in advance or when presenting for care. Between 850,000 and 900,000 families and all senior citizens receiving the universal food pension were considered potential rights-based claimants to the PFMMS. In order to increase the likelihood that the poorest families—those who typically do not access health services and who also have the most limited ability to fight with bureaucracies—became rights-based claimants, and intense publicity was carried out in the neighborhoods suffering from

high and very high levels of marginalization. Towards the end of 2006, 854,000 family units had been registered in the program. In practical terms, this is equivalent to universal coverage (Table 1).

The fundamental conceptual differences and the very real differences in benefits between the federal program and the Mexico City program led to a dispute between the local and federal governments. When *Seguro Popular* took effect in 2004, Mexico City's government declined to participate in the program. It objected to the limitations placed on the right to health and argued that it did not want to harm the City's residents by taking away rights which they already enjoyed in the PFMMS (a program entirely funded by the Mexico City government). The financial resources offered by *Seguro Popular* represented less than 5% of the Health Department's budget and the delivery of these funds would prove to be quite erratic.

By that time substantial progress had been made enrolling families in the PFMMS; 550,000 family units (two thirds of all those who were eligible) had

Table 1. Comparison of the Free Medicines and Medical Services Program (PFMMS) with *Seguro Popular*

	PFMMS	Seguro Popular (Art. 71 bis LGS)
Criteria for Benefits	Resident of Mexico City No existing health insurance Completing an application	Resident of Mexico City No existing health insurance Completing an application Payment of a family fee Yearly renewal of membership and yearly fee
Criteria for Exclusion	Participation in employment-based Social Security	Failure to renew membership and pay fees Specific clauses outline reasons for rejection.
Enrollment Schedule	According to demand	14.3% of eligible families each year (universal enrollment delayed until 2010)
Financing	Local and federal fiscal resources, [ramo 33 FASSA]	Federal social funds Federal solidarity funds [ramo 33 FASSA] State solidarity funds Yearly, nonrefundable, prepaid family fee based on a review of family's socio-economic status Regulated users' fees for certain services
Guaranteed Benefits	All of the existing services in the SSDF	Package of 272 services with corresponding medications Certain "catastrophic" coverage for some patients Everything else paid by user's fees
Organizational Structure	No special administrative structure.	A special administrative structure "State Controller of the SPSS", regulated and coordinated by the National Commission of the SPSS, an independent organ of the Federal Ministry of Health (SSA)
Service Provider	Mexico City Health Department	State hospitals and health care centers along with private hospitals

Table 2: Services provided in the Health Department and coverage by the PFMMS, 2006

Services	Total Number	Exempted from Fees ¹	PFMMS	
			Number	% of Total Services
Health Care Centers				
Outpatient Consultations	3,416,259		2,598,026	76.1
X-Rays	131,039		95,794	73.1
Laboratory Tests	2,348,006		1,858,854	79.2
Free Prescriptions			902,280	
Hospitals				
Outpatient Consultations	974,896	1,689	857,219	87.9
Hospitalization	120,162	5,931	90,958	75.7
Emergencies ^{2/}	765,740	Free for everyone ²	765,740	100.0
X-Rays	434,885	524	419,628	96.5
Tomography	16,160		15,748	97.5
Ultrasound	36,255		35,080	96.8
Laboratory Studies	2,987,582	1,181	2,965,600	99.3
Free Prescriptions			219,005	

^{1/} Those who are not members of the PFMMS, but who due to their socio-economic situation do not pay. ^{2/} As an institutional policy, emergency services are provided free of charge. *Source:* SIS and data from the Dept of Planning of the SSDF, 2006

already enrolled in the PFMMS. *Seguro Popular*, on the other hand, allowed only a limited number of new members each year. A policy of gradual enrollment would have forced the adoption of discriminatory practices in which those who were already members would have access to services denied to non-members.

At the beginning of 2005, the Mexican President went on the offensive against Mexico City's Governor. As part of this campaign the Federal Ministry of Health (SSA) launched an intense media campaign to force Mexico City's government to accept *Seguro Popular*. During bilateral negotiations, the SSA demonstrated a lack of commitment to respecting political diversity and tried to impose conditions violating the very legal structure of *Seguro Popular* itself.⁷ An agreement was finally signed exempting the city's inhabitants from all enrollment fees or from any limitations on access to services; enrollment in *Seguro Popular* was considered

equivalent to enrollment in the PFMMS. At the same time a very intense campaign was launched in medical units against a differential treatment amongst users, banning all discrimination in services.

The growing enrollment in the PFMMS translated into a high percentage of free services compared to total number of services provided (see Table 2). Ninety-five percent of the Mexico City residents who are hospitalized receive free care. With respect to hospitalization, it is worth noting that approximately 20 percent of the registered patients are not Mexico City residents. Fees recovered from non-Mexico City residents cover only the costs of laboratory studies, as well as X-rays; they are considered "free" in the Table. Medications given in the hospital—typically the most complex and expensive medicines—are provided free of cost to non-residents.

Another aspect of PFMMS's impact on improving living conditions is apparent in the very conser-

⁷Article 77 bis of the General Health Law

vative estimates that affiliated families saved roughly \$356 million dollars between 2002 and 2006. These resources could then be directed towards satisfying other basic needs.

One of the operative difficulties in the free program, particularly for costly medical interventions, was that the states neighboring on Mexico City charged for medical services and only provided prescriptions, not actual medications. The Health Department lacked both the budget and infrastructure to make up for the deficiencies of the other state governments and of the federal hospitals. In spite of this the Health Department took measures so as not harm the most needy. First, the Health Department exempted poor patients who were not Mexico City residents from all charges. Second, the Health Department adopted a policy of free emergency assistance, irrespective of geographical origin or insurance status. The acceptance of the principle that emergency cases should be treated at no cost was accepted by all public health institutions with medical units in Mexico City and was formalized in an agreement signed in 2005 after long negotiations.

In order to guarantee the continuity of the PFMMS and to establish that the government was legally responsible for guaranteeing health care through the Plan, the Governor proposed a new law, approved in May of 2006. In the *Law Establishing the Right to Free Access to Health Care and Medicines for Mexico City Residents Not Enrolled in Social Security (Ley que Establece el Derecho al Acceso Gratuito a los Servicios Médicos y Medicamentos a las Personas Residentes en el Distrito Federal que Carecen de Seguridad Social Laboral, Mexico City's Official Gazette, 2006)* the right to health protection is recognized, and the City government is made the explicit guarantor of this right for the non-insured population. It is worth emphasizing that this law follows the text of the Mexican Constitution more closely than the current *General Health Law*.⁸ The *General Health Law* allows there to be different “modalities” for accessing services, including payment of a users fee, pur-

chase of *Seguro Popular*, or agreement between a private or public provider and the user.

In order to assure that the PFMMS did not simply remain at the planning stage, but rather became a tangible reality for capital city's inhabitants, two agendas had to be advanced. It had to be operationalized through a process of expansion and improvement in health services as well as by institutional strengthening. It was crucial that the model of providing health care changed and public institutions thoroughly transformed.

The New Model for Health Care

The new model for health care—called the Expanded Health Care Model (*Modelo Atención Ampliada a la Salud (MAS)*)—envisaged the delivery of integrated and efficient health services at three different levels. These were conceptualized as the collective, the community, and the individual. The concept and practice of MAS was strikingly different from the “Service Packages” offered by *Seguro Popular*. These packages separate individual and community care. Further, by paying for some services while denying others, the packages disrupt the process of providing comprehensive care.

MAS was built on four pillars: 1) guaranteeing sanitary security for the city, including the gradual construction of a unified emergency system; 2) enhancing education, health promotion, and disease prevention; 3) guaranteeing timely and non-discriminatory access to needed services; and 4) extending citizen participation and social control. To these pillars was added the work of institutional reconstruction (as discussed below).

Sanitary security is an obvious priority for Mexico City. It is located in an earthquake zone. It has an extremely concentrated population, and it is vulnerable to the health problems associated with water, weather, industry and communicable diseases. Two programs were developed to deal with this situation. The epidemiological reporting system was reinforced. A particularly significant step in this process was the inculcation of a new spirit of professionalism which broke with prior patterns of deception.⁹ This allowed a renovation of epidemiol-

⁸See articles 1, 36, 77-bis, 38 and 40.

⁹Previously the emphasis was on “fulfilling the quota.”

ogical practice. New epidemiological risks, such as SARS and anthrax, were confronted and several epidemics fought.

Another necessary step was the development of the Integrated Medical Emergency System (*Sistema Integral de Urgencias Médicas, SIUM*) to coordinate and recondition all health care units to respond to a disaster in the city. As part of this effort, comprehensive planning along with drills and preparedness training were carried out. Within the SIUM a unified emergency care system was established. This was directed by the Medical Emergency Control Center operated from the Secretary of Health. The creation of the Center significantly reduced the number of patients rejected by hospitals as well as delays in arriving at the hospital. This resulted in substantial improvements in mortality and disability.

There is broad agreement that the best health systems are those which emphasize education, health promotion, and disease prevention. Nevertheless, in Mexico, as is the case in most countries, the health culture—both lay and institutional—is very medicalized. Curative services are at the core. This complicates the development of a wellness and prevention orientation. The Health Department created two new initiatives to address this situation. First, it reorganized the student health service and began to train Child Health Promoters in public schools. The idea was that cultural change is an extended process in which the young hold a privileged position. Twenty-one thousand child promoters received training through this program.

Second, the SSDF started promoting *Integrated Actions in Health*. This set of interventions—including health promotion, disease prevention, early detection, and secondary prevention—were provided to all users of the health care centers. The same approach was used in a pilot project for epidemiological surveillance of the chronic-degenerative diseases which rank first in the causes of death in Mexico City.

The HIV-AIDS program in Mexico City, created in 2001, is a particularly well-developed example of a comprehensive program with solid citizen participation. The program combines prevention and care, based on the transverse axes of social participation with a strong emphasis on non-

discrimination and advanced biomedicine. It has been extraordinarily successful. AIDS mortality was reduced by 16 percent in four years with significant improvements in early detection and prevention. The program illustrates a policy that attempts to combat discrimination both in the health system and through the health care system using practices which are respectful of gender, sexual preference, and ethnic differences. Sexual and reproductive health programs, as well as programs against gender violence, were developed with the same spirit.

For several decades, community participation in the health system had been discussed in Mexico. Yet, at the very best, this simply meant “voluntary” work within health units as a condition for access while, in the worst cases, it referred to serving patronage or even to corporate control. Completely overhauling this system is fundamental for any democratic governance, but—given the deep roots of these practices in the national political culture—this is a very complex task.

The basic idea of popular participation and social control—as they were understood by the Health Department—was that there exists a reciprocal relationship of rights and duties between the government and the population. With regard to health, the government is obliged to guarantee the right to health and to promote and facilitate popular participation. This means providing the necessary information on the specific content of this right. Once this has been achieved, the population has a reciprocal responsibility for the efficient use and social control of public resources. After all, these are the people’s resources. This “contract” between the government and society is the mark of a democratic and socially responsible government.

Within the general framework of promoting citizen participation, the Health Department created hundreds of health commissions in neighborhood assemblies organized by the City government. The commissions were asked to come up with a community health diagnosis and an action plan for their Territorial Unit.¹⁰ This was done after a period of

¹⁰Territorial Units are the third and lowest level of political structure in Mexico City. The three levels are: City government, Political Delegations and Territorial Units.

training and with the assistance of health educators. Existing health committees were restructured and integrated into the health commissions. The commissions were given decision-making power and charged with supervising the provision of services in health care centers. The results of these initiatives were variable and depended in great part on the personal characteristics of the citizens who got involved. The fundamental problem was the long tradition of social organizations built on patronage and favoritism, a heritage of the political party which had controlled the country for seven decades. The lack of democratic and representative organizations delayed the full institutional development of the health commissions and led to a certain fragility as their conditions changed.

Rebuilding Public Institutions

The destruction of the institutional fabric, consequence of the structural adjustment policies initiated in 1983, was immeasurable when viewed from within the Health Department. On the one hand a sense of inertia was everywhere, consequence of chronic underfunding. And on the other hand public institutions were discredited, the necessary step in the process of eventual privatization. The new government thus received an inefficient and ineffective institution: run down facilities that were inadequate for the new health needs of the city; a chaotic administration, and a less-than optimal organizational culture. All of these made it difficult to work towards the goal of guaranteeing the right to health protection, serving users with dignity, and creating a new health culture.

For several reasons, the reconstruction, or even reformulation, of public institutions is the central task of a left-wing government. At the conceptual level institutional arrangements are the materialization of the different ways in which social practice, such as health care, can be organized. These arrangements can meet social needs, in which case, public institutions must play a leading role. Or they can respond to the needs of profit in which case market forces and private enterprise take the lead. From a historical point of view the universal right to health is most efficiently guaranteed through official state programs or quasi-public plans. (Lister, 2007) For a left-wing government, redistribution of

income is a central task and one way to bring this about is through free and public provision of services. This is particularly important in Mexico where the public sector has been and is still the principal service provider despite years of neglect. (Laurell, 2007)

To understand the reasons for the deterioration of the Health Department and its public functions, it is necessary to examine two distinct aspects. There were the economic limitations imposed by a tight budget and the resulting decline in material resources. There was also an institutional culture and a certain way of seeing public resources that was seeped in patronage and political favoritism. These characteristics reinforced one another; institutional poverty increased the dominance of special interests over the public interest and the use of public resources for personal advantage—as well as outright corruption—further impoverished the institution. What is more, these factors ended up demoralizing and alienating both staff and patients, who suffered from the poor conditions in the medical units. Political patronage is based on the granting of favors in return for subordination or silence in the presence of abuse. It promotes the culture of the bribe and stifles the idea of exercising rights.

Under these conditions, the reconstruction of an institutional fabric had to develop along distinct lines. Paradoxically, the simplest part was the expansion of services and the re-equipping of the institution. This called for political will, money and administrative integrity. And these resources were effectively mobilized. In contrast with what had been happening for almost two decades, health became a top priority for the 2000-2006 administration and this was reflected in an increase of financial resources for the Health Department. The Health Department's budget for health services grew by 80 percent during this period.

A strategic and systematic planning of services was carried out based on health needs. The results of this planning were the construction of two new hospitals built in marginalized and underserved areas. Another 24 hospitals underwent either expansion and development or re-equipping. As a result, the number of public hospital beds increased by 1/3. Similarly, five new health centers were built; they were placed in areas that did not previ-

ously have health care centers. All told, \$200 million dollars were invested in construction, equipment, and maintenance of the health care centers and hospitals.

The Secretary of Health received many requests for additional projects from either citizens or organizations. It responded by explaining the criteria used to determine which investments were considered priorities. It was generally possible to convince petitioners that decisions were made impartially and justly by appealing to their understanding that the needs of other city inhabitants, neighborhoods, or barrios were more urgent.

Another aspect of institutional rebuilding was the restructuring of public administration. The two key elements of this reform were 1) the efficient and transparent use of public resources, and 2) the fight against corruption. Administering an institution with the size and scope of the Health Department is complicated by the multiple different processes that must work harmoniously toward a common goal of providing adequate health care to the community and to those who are ill. Health care is delivered in an emotionally charged setting due to the threatening and disturbing presence of illness and injury. While it is bothersome to have to go to a government office several times in order to resolve a problem; it is far more distressing to receive health care in an uncaring and underequipped facility.

It was particularly critical that medicines and other supplies were available in the facilities. Both were seen as vitally important for providing adequate health care and both had to be purchased in a market that was subject to frequent manipulation. The solution to this situation typifies the new types of administrative processes that were developed. A new management system for supplies (SAICA) was set-up, a medications system with a novel methodology for directly measuring pharmaceutical usage in each service. The procurement process was thoroughly overhauled to eliminate corrupt and monopolistic practices. These measures allowed the system to maintain an adequate supply of medications—especially essential medicines—, minimize the influence of purely commercial interests, and reduce prices by an average of 23 percent. The new structure eliminated opportunities for corruption..

The fight against corruption, central to institutional reconstruction, had to become a new part of our daily routine; corruption is ubiquitous in Mexican society. The campaign had to bring transparency to materials management, overcome the fear of reporting fraud, and root out corrupt practices. Some of these practices were not even seen as being corrupt, rather they were seen as institutional customs or norms, even as informal “work benefits”. These types of corruption are linked to the complete reversal of institutional values in which the public interest is subordinated to special interests; this phenomenon expresses the essence of the patronage system in its crudest form.

One way to set institutional values right again was to insist that the true function of any Health Department is to protect the health of the population. The existence of a Health Department is only justified to the extent it fulfills that mission. The objective of this reminder was to restore the institution’s ethical vision by appealing to the humanitarian content of its daily work. This new ethic of public service gained credibility because the corresponded to the visible actions of the City administration.

The so-called *Republican Austerity* program, started in 2000, also had a major impact. All senior officials of the new government took a 15% pay cut and superfluous expenses were eliminated. The approximately \$300 million saved by this Plan was used to fund social programs. The new management style was characterized by the evident honesty of the main functionaries; direct citizen access to functionaries for the resolution of problems; the vigilance of citizen comptrollers¹¹ over all purchases; and a mutual respect for the collective and institutional contract with the SSDF Union, etc..

The building of new hospitals brought the opportunity to experiment with architectural design and new models of health care which would place patients and their families in the center of all activities. The idea underlying these experiments was that new public values and practices could be materialized in a new spatial design and in new modes

¹¹All procurement and works committees included “citizen comptrollers.” They had access to all meetings and to all documentation concerning the bidding process. This allowed for the transparent use of public monies.

of providing care.

Progress in the exercise of the right to health

Institutional reconstruction was, in itself, important in the creation of a proper environment for the delivery of health care. This had positive effects for both the users and employees. This was a precondition for cultural change. Health had to be seen as a right that could be demanded rather than a gift. Intensive campaigns were carried out within the medical units explaining patients' rights and a mechanism set up so that complaints were directed to the highest administrative levels.

The most important element in promoting awareness of the right to health was the *Free Medicines and Medical Services Program* itself. In a survey among registered beneficiaries, 83 per cent knew that the right to health was in the Constitution, 87 percent considered that tax money should be dedicated to improve health, and 78 percent agreed that health should be a government responsibility.

At first, health care and hospital employees were somewhat resistant to the PFMMS because of the ways in which the right to health was operationalized. Nevertheless, toward the end of this administration's term, the results of an opinion survey and of discussion circles found that among both the administration and employees there was increasing

acceptance of the program, along with the idea that citizens had a right to demand health services.

Statistics on services delivered between 2000 and 2006 (Table 3) demonstrates the true exercise of this right. Health Department services were acceptable to and used by Mexico City residents. During the years of left administration there was a notable increase in all of the services, most particularly in the most costly ones: surgeries increased by 85%; births by 44 per cent; X-ray studies by 42%, emergency visits by 34%, and hospitalizations by 30%. All this during a time when the volume of outpatient consultations was essentially unchanged.

The PFMMS increased accessibility of services. But these data seem to reflect stronger and improved institutions. For instance, almost all pregnant women in Mexico City have a physician present at their delivery. The increasing number of births in public hospitals speaks for a patient preference for the public system rather than for small private clinics. This change, in and of itself, directly impacts on maternal mortality in the city.

One of the recurring objections to free provision of health services is that the middle class will take advantage of them. This did not happen in Mexico City's case. A survey of affiliated members of the PFMMS's found that their income and education levels were lower than that of the general population and that most users lived in areas of high or

Table 3. Changes the provision of health care services, 2000-2006

Services	2000	2006*	Percentage change 2000 to 2006
Outpatient Consultations	4,818,207	4,758,941	-1.2
Emergencies ¹	572,024	765,740	33.9
Hospital Discharges	89,973	120,162	30.1
Hospital utilization	56.4	71.9	27.5
Average Hospitalization (Days)	4.4	4.1	-6.8
Surgeries	42,564	78,576	84.6
Births	30,922	44,632	44.3
X-ray studies	404,878	573,700	41.7
Laboratory Studies	4'345,710	5'410,532	24.5

Estimation based on the last trimester of 2006; ¹Includes hospital ERs; public events, poison control centers; Source: Health Information System (SIS), SSDF, 2006

Table 4. Mortality Rate per 1000 population, Mexico City, 1997-2005

Years	General		Infantile ¹		Pre-schoolers		Students		Working Ages		Retired	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
1997	46,884	5.4	3,848	24.0	425	0.8	459	0.28	17,571	3.2	24,560	52.2
1998	46,773	5.4	3,699	23.6	445	0.7	440	0.27	17,336	3.0	24,840	49.5
1999	46,601	5.3	3,323	21.6	381	0.6	376	0.23	16,711	2.8	25,793	49.9
2000	46,029	5.2	3,127	21.6	365	0.6	402	0.26	16,535	2.8	25,567	47.8
2001	46,627	5.3	2,894	20.0	384	0.7	396	0.26	17,003	2.8	25,931	47.3
2002	46,984	5.3	2,858	19.9	368	0.6	378	0.25	16,875	2.8	26,490	47.0
2003	48,586	5.5	2,807	19.7	340	0.6	408	0.27	17,289	2.9	27,716	48.0
2004	48,950	5.6	2,676	19.0	349	0.6	352	0.24	17,032	2.8	28,541	48.1
2005	49,882	5.7	2,591	18.7	322	0.6	398	0.28	17,283	2.8	29,257	48.1
Change			-1,257	-22.3	-103	-25.5	-61	-2.4	-288	-11.3	+4,697	-7.9

¹per 1000 newborns: Source: Proyecciones de la población y NV en Mexico 1996-2030 and 2000-2030, CONAPO. Deaths: INEGI/SSA

very high marginalization. In other words, this universal program favored the poorest sectors of the population; yet did not run into the many problems and injustices associated with targeted interventions. (Mkandawire, 2005)

Finally, the data on the program's impact on the health of Mexico City's inhabitants provides clear verification of the project's success. Of course we must keep in mind that health services can have only a limited impact on health outcomes; in the final analysis health outcomes depend upon living and working conditions. However, with this limitation in mind and the additional proviso that, alongside the Health Department there are other institutions which also tend to Mexico City's population [such as the Institute of Social Security (IMSS) and the Institute of Social Services and Security for State Employees (ISSSTE)], it is interesting to see that mortality rates in all age groups declined from 1997 to 2005 (Table 4).

Of special interest is the decline in mortality rates for those in their productive and post-productive years. Typically, when mortality rates

decline in the younger age groups, it increases in the older age groups. This did not occur in Mexico City, probably because of improvements in health care services.

A final reflection is necessary on the vicissitudes of the Health Department in its efforts to (re)construct these public institutions so as to guarantee health rights. As has been mentioned, the reequipping of the Health Department was an easier task than what might be called the 'reweaving' of the ethical fabric. This fabric was filled with personal interests and old vices. As the *Free Medicines and Medical Services Program* began introducing both institutional changes and material improvements, a new consciousness of public service developed. By contrast, it is far easier to construct an entirely new public institution, such as the universal food pension for senior citizens, that is based on a new constitutional right. This pension was created in an open forum where only the opposition political parties had any objections. The benefits created by this pension benefitted from a wide social consensus and the program was implemented outside of the

negotiations among the political parties. It could be said that society imposed this pension as a social right through the State and against the will of right-wing parties.

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