

The London School of Economics and Political Science

*Implementation of Health Policies in Mexico City:
What factors contribute to more effective
service delivery?*

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Abstract

Policy failure has been a concern for social scientists during the past four decades, yet there are no clear answers as to why certain policies are not put into practice as intended. Ineffective policy implementation in the health sector may result in poor services with consequences affecting the population's wellbeing. This thesis addresses the success or failure in translating policy into practice and the issues that contribute to it. In Mexico, two groundbreaking reforms in the health sector were implemented in the first decade of the 2000s: the Popular Health Insurance (PHI) programme and the termination of pregnancy law or *interrupción legal del embarazo* (ILE). The thesis uses these policies as case studies to understand how different factors influence policy implementation, particularly in Mexico City. Four factors are observed: actors involved and their beliefs, service delivery arrangements, managerial practices, and citizen participation and accountability. Most of these are frequently cited in the literature as key factors in public policy and service delivery. Qualitative methods were used to collect and analyse the data. The main sources of evidence were in-depth interviews, newspaper articles, official documents and other online news services and publications. It was found that the ideas, values and beliefs of actors are relevant throughout the implementation process, beyond agenda-setting and policy design processes. A decentralised service delivery implies relationships between federal and local level health authorities. The two case studies showed that personal values and beliefs of those in strategic positions determined these relationships which, in turn, influenced the implementation of both federal and local health policies. The engagement of citizen and CSOs in the implementation of these policies was also determined by their ideas and beliefs. However, no significant managerial practices were found within implementing agencies. Implementers' ideas and beliefs seemed to be more relevant in contexts with weak managerial and accountability mechanisms.

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List of Acronyms and Abbreviations

SPANISH	ENGLISH
ALAMES = Asociación Latinoamericana de Medicina Social	Latin American Social Medicine Association
ALDF = Asamblea Legislativa del Distrito Federal	Mexico City local legislative body of representatives
AMM = Alianza de Médicos Mexicanos	Alliance of Mexican Medical Professionals
AMMRI = Asociación Mexicana de Médicos Residentes e Internistas	Mexican Association of Medical Residents and Interns
ANDAR = Alianza Nacional por el Derecho a Decidir	National Alliance for the Right to Choice
ANHP = Asociación Nacional de Hospitales Privados	National Association of Private Hospitals
ANMM = Academia Nacional de Medicina de México	National Medical Academy of Mexico
CDD = Católicas por el Derecho a Decidir	Mexican Catholics for Choice
CDHDF = Comisión de Derechos Humanos del Distrito Federal	Mexico City Human Rights Commission
CNDH = Comisión Nacional de Derechos Humanos	National Human Rights Commission
CNPSS = Comisión Nacional de Protección Social en Salud	National Commission for Social Protection in Health
COFEPRIS = Comisión Federal de Protección contra Riesgos Sanitarios	Federal Commission for Protection against Sanitary Risks
COMEGO = Colegio Mexicano de Especialistas en Ginecología y Obstetricia	Mexican Association of Gynaecology and Obstetrics Specialists
CONAMED = Comisión Nacional de Arbitraje Médico	National Commission of Medical Arbitration
CSG = Consejo de Salubridad General	General Health Council
CTM = Confederación de Trabajadores de México	Confederation of Mexican Workers
DIF = Sistema para el Desarrollo Integral de la Familia	National system of social assistance
FPGC = Fondo de Protección contra Gastos Catastróficos	Fund for Protection against Catastrophic Expenditures
Funsalud = Fundación Mexicana para la Salud	Mexican Health Foundation
GDF = Gobierno del Distrito Federal	Mexico City government
GIRE = Grupo de Información en Reproducción Elegida	Information Group on Reproductive Choice
ILE = Interrupción Legal del Embarazo	Legal termination of pregnancy. Name given by the law to the elective abortion programme
IMSS = Instituto Mexicano del Seguro Social	Social Security Institution for private sector workers
INSP = Instituto Nacional de Salud Pública	National Institute of Public Health
ISSSTE = Instituto de Seguridad Social y Servicios para los Trabajadores del Estado	Social Security Institution for public service employees
PAC = Programa de Ampliación de Cobertura	Programme for Extending Coverage
PAN = Partido Acción Nacional	National Action Party
PASSPA = Programa de Apoyo a los Servicios de Salud para Población Abierta	Programme to Support Health care Services to the Uninsured Population
PEMEX = Petróleos Mexicanos	Mexican Oil Company (state-owned)
PRD = Partido de la Revolución Democrática	Party of the Democratic Revolution
PRI = Partido Revolucionario Institucional	Institutional Revolutionary Party
SEDENA = Secretaría de la Defensa Nacional	Army

SPANISH	ENGLISH
SEDESOL = Secretaría de Desarrollo Social	Social Development Ministry
SEMAR = Secretaría de Marina	Navy
SPSS = Sistema de Protección Social en Salud	System of Social Protection in Health
SSA = Secretaría de Salud	Federal Secretary or Ministry of Health
SSDF = Secretaría de Salud del Distrito Federal	Mexico City Department of Health
UAM = Universidad Autónoma Metropolitana	Metropolitan Autonomous University
UNAM = Universidad Autónoma de México	National Autonomous University of Mexico

ENGLISH
ACF = Advocacy Coalitions Framework
CFFC = Catholics for a Free Choice
CSO = Civil Society Organisation
GP = General Practitioner
IAD = Institutional Analysis and Development framework
IDB = Inter-American Development Bank
IPPF = International Planned Parenthood Federation
LSHTM = London School of Hygiene and Tropical Medicine
MDGs = Millennium Development Goals
MVA = Manual Vacuum Aspiration
NAFTA = North American Free Trade Agreement
NGO = Nongovernmental Organisation
NPM = New Public Management
PHI = Popular Health Insurance
WHO = World Health Organisation

1 Introduction

Policy failure has been a concern for social scientists throughout the past four decades, yet there are no clear answers as to why certain policies are not put into practice as intended. In the 1970s, the works of Pressman and Wildavsky (1973) marked the beginning of a research area within policy studies concerned, specifically, with policy implementation. They ask why well-designed federal policies fail to be carried out in local contexts. The most common answer that researchers give to similar questions is one of bad execution. The “implementation gap” (Dunsire 1978) became the focus of this area of policy studies. Despite the ample amount of implementation studies, the question still remains. Saetren (2005) states that, after several decades of research on public policy implementation, “we know surprisingly little”. Hargrove (1975) refers to the study of implementation as the “missing link” in policy analysis. More than three decades later, Robichau and Lynn (2009) state that implementation “continues to be the missing link in public policy theories”. A better understanding of the issues that influence the way policies are put into practice is still needed.

Ineffective policy implementation in sectors such as health, education, water and sanitation, energy supply, and social security, are particularly important given that these sectors involve delivery of essential public services to the population. The study of policy implementation can include the provision of services. Poor service delivery, especially in the developing world, has also been a major concern. International organisations, such as the World Bank, have stressed the need to improve the provision of basic services. The World Development Report 2004 is devoted to “making services work for poor people”. It argues that services are failing in access, in quantity, and in quality (World Bank 2003). Also, the World Health Organisation (WHO) and the Inter-American Development Bank (IDB) recognise that improving the provision of services is one of the key measures to achieve the Millennium Development Goals (MDGs).¹ These organisations urge governments of developing

¹ The Millennium Development Goals were adopted by the United Nations and development organisations like the World Bank in the year 2000. They form a blueprint for working together for a common end. There are eight goals and each has specific measurable targets. They range from halving

countries to focus their attention on the provision of basic services such as health (Stein and Tommasi 2008; WHO 2000, 2005; World Bank 1993). Health care is at the centre of the development agenda, while three out of the eight MDGs are directly related to health: to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases (UN 2000).

The MDGs encourage governments to amend or introduce new policies that contribute to their achievement. In Mexico, two groundbreaking reforms in the health sector were put into practice during the first decade of the 2000s: the Popular Health Insurance programme (PHI), or *Seguro Popular*, (providing health care coverage to previously excluded populations) and the ILE, or *interrupción legal del embarazo*, (decriminalising voluntary abortion during the first trimester). As a federation, health policies and their implementation are different among the constituent states. Voluntary abortion is legal only in Mexico City, while the PHI is a nation-wide policy. The pregnancy termination programme numbers (number of people attending, number of establishments offering the service) show a seemingly effective implementation of this policy.² Why has such a controversial policy been successful? What are the factors that have contributed to its success? Whilst Mexico City has had relative success in the implementation of the abortion policy, it has done less well with regard to social insurance. Mexico City has the lowest percentage of population covered by the PHI programme and has the lowest insurance policy renewal rate in the country.³

The goal of this thesis is to understand why health policies in Mexico City are, or are not, carried out as intended and why this differs across policies. The above questions are addressed in order to learn of the issues that contribute to the success or failure of translating policy into practice. Effective policy implementation leads to better health service delivery. A closer look at the way policies are being carried out

extreme poverty to halting the spread of HIV/AIDS and providing universal primary education. The target date is the year 2015. For more information see <http://www.undp.org/mdg/basics.shtml> and <http://www.un.org/millenniumgoals/bkgd.shtml>

² From April 2007 (when induced abortion was decriminalised) to October 2010, the total number of procedures carried out in public hospitals was 48,138; from which only 6% of patients were underage (up to 18 years old) and 70% of procedures used medication rather than other more invasive methods like curettage. Source: SSDF through GIRE at <http://www.gire.org.mx/contenido.php?informacion=222>, accessed on 17/Dec/2010

³ Mexico City's PHI coverage is 56% of the total target population, the lowest in the country. The national average of coverage is 88.5%. Insurance policy renewal in Mexico City is 11.7% while the national average is 73.1% (figures by December 2010). Source: Comisión Nacional de Protección Social en Salud, 'Informe de Resultados 2009', (México, DF: CNPSS, Secretaría de Salud, 2010).

after they are enacted contributes to a better understanding of those factors that enable or constrain policy implementation. This thesis seeks to offer both politicians and service providers a study that can provide guidance for future policy and decision-making. It is not, however, concerned with the actual content of policies or their effects on health outcomes. The focus is on the process through which policies are put into effect and transformed into action. It focuses on four issues that influence processes of policy implementation: the actors involved and their beliefs, service delivery arrangements, management practices, and citizen participation. Most of these are frequently cited in the literature as key factors in public policy and service delivery as explained in the following sections. By actors involved I mean the individuals, institutions and agencies that advocate the policy or are in charge of execution. Service delivery arrangements are the modes through which services are delivered to the population; for example, central government provision, contracting out to the private sector and nongovernmental organisations (NGOs), decentralisation to local governments, or community participation. By management practices, I refer to elements such as stating clear goals, providing incentives and controls, monitoring performance, delegating functions and responsibilities. Citizen and community participation involves accountability mechanisms by which service users can monitor service providers and make them more responsive to their needs, for example public complaints bureaus, advisory boards, and human rights commissions/ombudsmen or ombudswomen.

The thesis pays particular attention to one issue that has received very little attention in the service delivery literature, despite its increasing relevance. It studies whether the values and beliefs held by actors involved in the process play a crucial role in determining effective policy implementation. The thesis focuses on the following questions: Why does a policymaker or politician decide to support or reject a policy? Why does a manager execute, or not, an instruction? Why does a service provider deliver or restrict a service? These are all questions related to the values and beliefs that condition the behaviour and actions of those actors. In times of increased population mobility and globalisation, societies are becoming ever more plural and diverse. This diversity causes – often confronting – values and beliefs to co-exist in the same territory. The implications of this phenomenon for public policy and service delivery are not yet addressed nor fully understood. This is more obvious in controversial policies such as voluntary abortion, same-sex marriage and adoption

rights, death penalty, euthanasia, fertility treatments, and stem cell medical research. But are the values and beliefs of policymakers, managers and service providers also relevant for less controversial policies, such as the PHI programme? Do these become more relevant under certain conditions or contexts where accountability mechanisms are not well developed?

Differences in the beliefs and values of policy actors are not only observed during policy design and negotiation, as often noted, but also at the point of service delivery, which determines access to services. There seems to be no clear answer to this issue. The ILE policy in Mexico City allows for “conscientious objection”⁴ so that medical professionals may refuse to perform abortions if it goes against their beliefs. In contrast, the state Supreme Court in California, USA, decided that doctors could not refuse medical treatment to homosexuals even if it conflicts with the doctors’ religious beliefs. This decision came after a woman was refused intrauterine insemination in a women’s care clinic because the religious beliefs of the medical staff prevented them from providing the service to a lesbian.⁵ In July 2008, a tribunal in London ruled in favour of a marriage registrar who refused to carry out same-sex civil partnerships because of her Christian beliefs. She claimed she was being bullied and picked on for refusing to perform these partnership ceremonies. The tribunal ruled that she was discriminated against on the grounds of religious beliefs.⁶ In the same year, a therapist of the charity “Relate” in the UK, which provides relationship support, was fired for refusing to give therapy to gay couples because of his beliefs and principles. In this case, the court ruled against him.⁷

The thesis addresses the issue of conflicting values and beliefs in the implementation of a controversial policy like the ILE policy approved in Mexico City in 2007. It contrasts this with a policy that is not so morally charged, such as the PHI programme. This analysis is useful to understand how values and beliefs of policy actors may influence the effective implementation of controversial and less controversial health policies.

⁴ Conscientious objection is based on principles of religious freedom and protects medical practitioners who refuse participation in medical procedures that are against their religious beliefs and conscience; in B. M. Dickens and R. J. Cook, 'The Scope and Limits of Conscientious Objection', *International Journal of Gynecology & Obstetrics*, 71/1 (2000), 71-77.

⁵ Dolan, M. (2008). ‘Doctors’ faith must yield to gays’ rights, court says’, *Los Angeles Times*.

⁶ BBC News (2008). ‘Registrar wins same-sex tribunal’.

⁷ BBC News (2010). ‘Christian sex therapist Gary McFarlane loses appeal bid’.

1.1 The case of Mexico City

Headlines such as “Mexico City rules out Popular Health Insurance” or “Government rejects Popular Health Insurance” dominated local and national newspapers in January 2005, one year after the start of the PHI, the most important health reform in Mexico during the 2000s. The Mexico City government refused to implement the reform. After tense negotiations, the local authorities agreed to sign up to the PHI at the end of July the same year. However, the operation of this reform was greatly undermined in the country’s capital and, five years on, it still lags behind all other states.

The Mexico City experience offers an interesting case that contributes to debates on policy implementation and service delivery. Mexico City is the capital of the country. Looking at how federal policies are carried out in the same place as where they were designed and approved challenges the assumption that Pressman and Wildavsky (1973) make in their seminal work *Implementation: how great expectations in Washington are dashed in Oakland*. The PHI programme was introduced in Mexico City in 2005. It is a federal policy designed by the Ministry of Health and, yet, Mexico City is the federal entity that has not implemented the PHI programme as it was originally intended. Mexico City was the last state to sign up to the Popular Health Insurance only after a year and a half of its enactment by the federal legislature. The capital of the country is behind all other states in PHI programme’s national evaluations.⁸ This case also addresses the interplay between different levels of government in a context of decentralised service provision. The implementation of a federal policy in a local context contributes to the understanding of the effects of decentralisation often raised in the literature, as explained in the following section.

The Popular Health Insurance programme is the health care insurance component of a package of reforms called System for Social Protection in Health (SPSS). This system was envisaged to achieve universal health care access by providing services to the uninsured population – accounting for approximately half of the total country’s population.⁹ The reformed law, published in May 2003, defines the SPSS as a mechanism through which the state guarantees effective, timely and quality access to health services free of charge at the point of service. It encompasses actions

⁸ Comisión Nacional de Protección Social en Salud, 'Informe de Resultados 2009'.

⁹ Secretaría de Salud, 'Sistema Nacional De Informacion En Salud', *Sistema de Cuentas en Salud a Nivel Federal y Estatal (SICUENTAS)* <<http://sinais.salud.gob.mx/recursosfinancieros/index.html>>

like health promotion, prevention, diagnosis, treatment and rehabilitation, including medication. Services include a minimum essential package including primary level attention and outpatient care, in addition to hospitalisation in areas such as internal medicine, general surgery, gynaecology and obstetrics, paediatrics and gerontology.

The ILE policy was introduced in Mexico City in 2007 after a heated debate in the local legislature as well as in the national media. In addition to being one of the most important reforms in the health sector in recent years, the analysis of this policy is interesting because of its controversial nature in terms of ethics and morality. Only one month after its approval, the new policy was constitutionally challenged in the Mexican Supreme Court of Justice by federal government agencies. However, 14 out of 16 hospitals managed by the local Health Department were already providing the service and had performed 247 abortions in the first month of operation. The implementation dimension of “morality” policies, which is highly contested on moral or ethical grounds (Haider-Markel 1999; Christopher Z. Mooney and Lee 2000; Christopher Z. Mooney and Schuldt 2008), has not yet been sufficiently addressed or understood. By analysing side-by-side two policies that are different in their morality nature, this thesis addresses the issue of how personal values and beliefs influence policy beyond setting agendas, designing and negotiating. The contrast between a morally-charged policy with another that is not is useful in order to understand the differences between these kinds of policies.

According to official data, unsafe abortion is the third most important cause of maternal mortality¹⁰ and it is recognised as a public health problem by Mexican health authorities. Although Mexico City approved the reform to decriminalise abortion in April 2007, access to safe abortion to women in the rest of the country is highly restricted.¹¹ The ILE policy is a groundbreaking reform in both criminal and public health laws. The reform decriminalises voluntary or induced abortions during the first trimester of pregnancy, and guarantees access to the service through the local public health care sub-system. The law grants medical staff in public health care institutions the right to conscientiously object, so that they can refuse to perform abortions based on personal beliefs. The change in local legislation created the possibility for private health care providers to lawfully perform induced abortions within the timeframe

¹⁰ Sistema Nacional de Información en Salud, base de datos de defunciones 2007 <http://www.sinais.salud.gob.mx/muertesmaternas/index.html>, accessed 10/11/2009.

¹¹ Most states in Mexico do not punish abortion in cases of rape, accident, or risk to the woman's life.

specified in the bill. Before this policy reform, abortions were carried out in clandestine conditions (Juárez et al. 2008).

The nature of this reform is intrinsically controversial in what is the second largest Catholic country in the world. The Catholic Church is one of the most powerful institutions in Mexico. National surveys show that citizens trust the Church above all other institutions such as the army, the judiciary, or the legislature.¹² The debate around the decriminalisation of abortion is highly contested in the public sphere. Civil society organisations (CSOs) were deeply involved in the debate for and against the reform prior to its approval. One month after its enactment, the reform was challenged in the Supreme Court by the conservative president of the National Human Rights Commission or *Comisión Nacional de Derechos Humanos* (CNDH) and the Attorney General of the federal government. One year later, in August 2008, the Supreme Court ratified the Mexico City's health reforms as constitutional. The day after the Court's announcement, the Metropolitan Cathedral and other main churches in Mexico City rang their bells for half an hour as a "sign of grief and mourning" as stated by Cardinal Rivera.¹³

Mexico's experience with health sector reforms in the 2000s, especially the PHI, has set the standards for similar reforms in Latin America and other middle-income countries around the world (Frenk and Horton 2006). It is, therefore, important to have a good understanding of the different issues that have come into play in the Mexican case, particularly as it is such a morally charged issue. As Frenk (2006) points out, because of Mexico's high social inequality and plural health system, the country is a microcosm of problems that affect countries at all levels of development. The Mexican case may offer lessons to countries not only with comparable contexts, but also with different levels of development.

Sexual and reproductive health is central in the international agenda, and the Mexico City case may offer lessons to other countries introducing similar policies. In other Latin America countries like Argentina, Brazil and Chile, voluntary abortion is on the political agenda. It is, therefore, relevant to look at the implications that the implementation of this kind of policy has for national health systems. From the perspective of the feminist movement, the ILE policy is also very significant. Mexico

¹² Consulta Mitofsky, National Household Survey "Trust in Institutions", February 2010 <http://72.52.156.225/Estudio.aspx?Estudio=confianza-instituciones> accessed 28/01/2011

¹³ José Antonio Román, 'En Catedral, duelo con media hora de campanadas', *La Jornada*, 29/August/2008 2008, sec. Capital.

has signed international conventions on women's rights such as the Cairo conference in 1994 and the Beijing conference in 1995. The high participation of civil society actors in introducing this policy reform and their role in its implementation illustrates citizens' engagement in policy processes. The analysis of this policy may provide useful insights into the translation into practice of sexual and reproductive health policies. The analysis of these two policies contributes to the debate on policy implementation in the literature of public policy analysis and service delivery. The next section reviews the main perspectives on these topics.

1.2 Overview of the literature

There are two main approaches in the literature that address the problem of policy implementation and service delivery improvement. One looks at it from a policy analysis perspective and the other as a public service delivery issue. The latter has a more practical approach, while the first is more interested in theorising.

International organisations assume that governments are responsible for the provision of basic services such as health and education. They argue that being responsible for service provision does not entail direct service delivery, but rather making sure that it is carried out by determined standards (Janovsky and Peters 2006; WHO 2007; World Bank 2003). The World Development Report 2004 suggests an analytical framework for looking into service delivery that includes methods of delivering these services, accountability mechanisms to monitor and discipline service providers, and citizens' participation to influence policymaking. This framework identifies three main actors in the service delivery chain: the policy-maker or politician, the provider, and the user or citizen. The basic assumption is that accountability should govern the relationships among the actors: "between citizens and providers, between citizens and policy-makers, and between policymakers and providers" (p.1). It argues that, by increasing citizens' choice and participation, they are able to hold providers to account. By increasing the citizen's voice through the ballot box, for example, they are able to increase their influence on politicians/policymakers. Some of the mechanisms the report suggests for achieving better service delivery are to separate policy-making from service delivery, contracting-out, regulation of private providers, performance controls and incentives, and competition in service provision (World Bank 2003).

Following the accountability approach in the service delivery chain, authors like Deininger and Mpuga (2005) address the question as to whether greater accountability improves the quality of service delivery. Using Uganda as a case study, they conclude that reporting inappropriate behaviour of bureaucrats and unsatisfactory quality of services does help to “not only reduce the incidence of corruption but is also associated with significant improvement in service quality” (p.171). Other authors, like Ahmad, Devarajan *et al.* (2005), argue that decentralisation mechanisms may transform relationships of accountability to improve service delivery. They develop a framework to evaluate changes in service delivery introduced by different types of decentralisation mechanisms such as fiscal, administrative, regulatory, market, and financial mechanisms. They conclude that the impacts of decentralisation on service delivery are mixed and depend on contextual characteristics. Mehrotra (2006) argues that, without accountability, services cannot be delivered effectively. He explains that, with the decentralisation of services to the local level, there is better information flow about local needs and grievances, thus allowing local decision-makers to respond to local conditions. Mehrotra’s focus is on the use of the collective voice in order to put pressure on local officials and providers to improve performance, thus the state should enable the collective voice to emerge.

Another approach to the problem of service delivery is the introduction of corporate managerial practices to the public sector, known as the New Public Management (NPM). It emphasises the use of incentives and controls in order to ensure effective implementation of policies and quality service delivery (Ambegaokar and Lush 2004; McLaughlin *et al.* 2001). The World Bank also talks about performance incentives for services providers (World Bank 2003). This approach suggests reduction of bureaucracy, streamlined management, increased cost-effectiveness, decentralised and reorganised services, and increased private sector involvement. In health care service delivery, researchers have looked into the effects of managerial mechanisms to improve service delivery. Loevinsohn and Harding (2005), for example, study ten cases in different countries that contract services out with non-state entities like nongovernmental organisations (NGOs). Their study shows that contracting for the delivery of primary health care can be very effective and that improvements can be rapid (p.676). Crampton, Dowell *et al.* (2001) study third sector involvement in providing primary care to vulnerable populations in New Zealand. Harding, Montagu *et al.* (2008) show that the private sector plays a

significant role in health care delivery across all income levels rather than only the better off. However, the lack of data on the activities of the private sector constrains the integration of the private sector into public health goals.

The principal-agent theory also addresses the problem of service delivery. It focuses on the relationship between “principals” who demand a service and “agents” who deliver it. The assumption is that individuals act on the basis of economic self-interest. The issue relates to how principals can manage or control agents’ performance to meet with the principals’ expectations. Batley and Larbi (2004) explain that, in public policy, “principals are ultimately citizens and agents are politicians and bureaucrats, but the whole structure of a public bureau can be seen as being governed by chains of principal-agent relationships” (p.35). This framework focuses on the information principals have about agents’ performance and the incentive mechanisms they use to elicit the desired behaviour from agents.

The public policy analysis perspective includes the politics of health care, that is, the study of relationships and power transactions among policy actors. It recognises that “politics affects the origins, formulation, and implementation of public policy in the health sector” (Glassman et al. 2008). For example, Lewis (2006) argues that the accumulation of, and use of, power is crucial to the health policy process. The author uses a policy and social networks approach to examine the power of the medical profession in Australia. Other scholars go further to link the political ideologies of governing parties to health outcomes. Navarro, Muntaner *et al.* (2006) examine the interaction between political traditions, policies and public health outcomes to see if different political traditions are associated with systematic patterns in population health over time (p.1033). In the case of Mexico, this approach to the study of service delivery is rare. González-Rossetti and Mogollon (2000) conducted a study on the political feasibility of health reform in Mexico and other Latin American countries. Their analysis takes into account the political economy context, the policy process and the political strategies used by reformers. They analyse the set of health reforms carried out in the 1990s. The study highlights the role of the labour unions of public health care institutions and the process of negotiation in Congress. Funsalud (1995), a Mexican think-tank specialised in health issues, also has a study that analyses the politics of health sector reform in the 1980s. However, most of the studies on these reforms focus mainly on health outcomes (Frenk et al. 2003; Frenk et al. 2006) and neglect the role of health care providers in the implementation of

policies (Abrantes Pêgo and Almeida 2002b; Fleury et al. 2000; González-Pier and Peña-Baca 2005; Tamez and Molina 2000b).

The IDB recognises the relevance of politics for understanding the possibilities of success of economic and social policies. The 2006 report “The Politics of Policy” (Stein et al. 2005) stresses the importance of understanding the processes by which policies are discussed, approved and implemented:

In presidential democracies like those in the majority of the Latin American countries, the process of adopting and implementing public policy occurs in political systems in which a variety of actors participate, ranging from the president to voters in small rural communities and including congressmen, judges, public opinion leaders and businessmen. (Stein et al. 2005, p.v)

This IDB report challenges the view that policy success is determined by its theoretical or technical attributes. It takes into account the institutional, political and cultural context where a policy is applied (p.4). The analytical framework sees the policy process as a dynamic game where actors interact in policy arenas. There is a focus on the role of actors and the arenas in which they interact. It is argued that the roles actors play are shaped by factors such as formal and informal rules, interests, preferences, and capabilities (p.25).

Very few authors focus on the relevance of health care providers’ values and beliefs in influencing implementation of new policies. For example, Harrison *et al.* (2000) made a study on South Africa’s Termination of Pregnancy Act introduced in the country in 1997. Among other findings, the authors argue that abortion is seen as contrary to prevailing community norms, and conclude that “legalisation alone cannot ensure implementation of abortion services. [...] a process of information dissemination and community consent prior to implementation is essential” (Harrison *et al.* 2000, p.424). However, studies like this one do not address other factors that influence implementation and are limited to controversial issues like abortion (see also Djohan *et al.* 1993).

These bodies of literature highlight the relevance of different factors involved in policy implementation. Decentralisation of services, accountability mechanisms, actors and players, power relations, choice and competition, performance controls and incentives, streamlined management, voice and community participation, institutions, economic and cultural contexts, are recurrent issues in the debate. In constructing an

analytical framework, I combine/condense these into four key categories of factors: (i) the role of actors involved and their beliefs, (ii) service delivery arrangements in place, (iii) corporate managerial practices, and (iv) citizens' participation and accountability mechanisms. The next section defines the research questions that guide this thesis to then introduce the analytical framework and methodology.

1.3 Research Questions and Hypotheses

The main goal of this thesis is to understand why, in some cases, policies are not executed as initially intended. The PHI programme and the ILE law in the context of Mexico City serve as case studies. Therefore, the research questions guiding this thesis are: *How are health policies in Mexico City put into practice? What factors may enable or constrain the effective implementation of policies?* By asking how policies are translated into practice, I place the focus on processes rather than outcomes. As previously explained, this thesis is not about the results or impacts of policy interventions, but rather about the way policies are executed and the factors that influence that process. This study is concerned with finding out what issues affect, and how they affect, the course of implementation processes.

Translating policy into practice is complex. To address that complexity, the approach of this thesis is to unpack different components or factors that policy implementation entails. It is necessary to ask more specific questions to address those components. From the main research question stem four sub-questions that aim to provide a deeper understanding of the factors that may enable or constrain implementation processes.

The first sub-question is: *Who is involved in advocating and implementing the policy? What are their ideas, values and beliefs about the policy?* This question aims to find out what governmental agencies and CSOs, as well as key individuals, support and execute the policy. It identifies the kind of relationships among them and how these relationships have been shaped. The second part of this sub-question enquires about the ideas, values and beliefs these players have towards the policy. This is important, as it enables us to understand their attitudes and behaviour throughout the implementation process.

There are different service delivery arrangements – direct state provision, contracting out with private providers, private provision, and so on - involving

different types of providers. The next sub-question aims to find out the delivery arrangements in place: *How is the service actually provided to the population? Do private and third sectors participate in service delivery?* Private providers refer to market-based for-profit service providers. By the third sector, I mean NGOs or charities that provide services on a non-profit basis.¹⁴ Particular attention is placed on the involvement of private and third sectors. Although the main health care provider in Mexico is the state, because the public health system is decentralised, there are federal and local government hospitals and health centres that provide services to the population. This sub-question addresses these distinctions.

Good management is often cited as one of the key factors to ensure successful policy implementation in the NPM literature (Kaul 1997; McLaughlin et al. 2001). Therefore, it is important to understand: *What managerial practices are in place within implementing agencies? How do they work?* Managerial practices may include performance monitoring and evaluation, incentive mechanisms, training of staff, clear authority relations, and distribution of functions and responsibilities.

A strand in the service delivery literature argues that a greater influence of citizens/clients in service provision results in improved services (Ackerman 2005; Fiszbein 2005; Gaventa and Cornwall 2001; World Bank 2003). The final sub-question asks: *Do service users or regular citizens participate in the implementation process? How are service providers held into account to users?* This aims to understand the extent of citizens' involvement in the implementation process. By citizens' involvement or participation, I refer to individual or collective actions that citizens carry out to voice their demands and needs. The ultimate purpose of these actions is improving service delivery, but also to hold service providers responsible. This sub-question enquires about the channels or mechanisms available to citizens to influence services and the way these are provided.

The research questions address how different factors suggested by the existing literature influence policy implementation processes. Sub-questions refer to specific factors that may enable or constrain the way policies are carried out. The argument is

¹⁴ Non-profit meaning “not dedicated to distributing profits to shareholders or directors...” Lester M. Salamon and Helmut K. Anheier, *The Emerging Nonprofit Sector : An Overview* (Johns Hopkins Nonprofit Sector Series 1; Manchester: Manchester University Press, 1996) 168p. In Mexico City, there are two legal designations for non-profits: “A.C.”, which stands for Civil Association, and “I.A.P” standing for Private Assistance Institution.

that policy values and beliefs are crucial in the implementation of policies. In order to unpack this argument, the following hypotheses are suggested.

Actors, values and beliefs

Actors involved in the implementation process, such as politicians, administrators and medical professionals, together with their values and beliefs, are central in determining effective implementation. Some of them may be organised in groups or coalitions sharing the same policy beliefs. These coalitions use their resources to influence not only policy change but implementation as well. Coalitions may constrain the implementation of policies that are based on different ideas and values than the ones they hold.

Delivery arrangements and management

In decentralised service provision, effective implementation is constrained if coalitions or individuals in decision-making positions, such as federal and local level governments, have different policy values and beliefs. Street-level bureaucrats may also constrain the delivery of a service depending on their values and beliefs, regardless of managerial practices. In a similar way, the values and beliefs of private and third sector health providers determine their participation in the implementation of public policies, especially where they are not legally and statutorily required to do so.

Citizens' participation

Citizens' engagement in the implementation process (as advisers and accountability agents) improves service delivery. Spaces or channels available to regular citizens/service users to voice their demands and needs enable a more effective policy implementation. However, some citizens' groups or CSOs may not be willing to participate.

These hypotheses attempt to give answers to the puzzle presented in this thesis. The rationale used in elaborating them becomes clearer with the analytical framework. Also, some of the concepts used in the hypotheses need further clarification. The next section explains these and how they are used in the analytical framework proposed here.

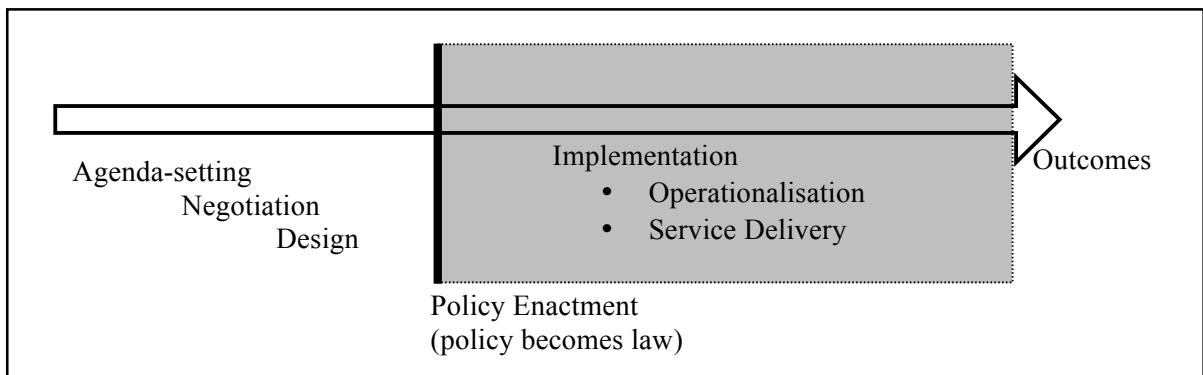
1.4 Analytical Framework

First, it is important to explain what the implementation process involves. This thesis studies what happens after a policy is approved by legislatures, that is, when it becomes a law. It does not focus on policy outcomes or impacts (see Figure 1.1). Before a policy is enacted, it is designed, discussed and negotiated; before that, the policy issue had to be put in the public agenda. All these are phases of the policy process that this study does not analyse. Rather, it focuses on how the policy is translated into practice after it is enacted: implementing agencies are defined, agreements are written, norms and regulations specific to the policy are elaborated, and services are delivered. I identify two analytical levels in the implementation process: operationalisation and service delivery. The former includes defining responsible agencies and their functions, writing agreements between agencies or institutions, and setting the norms and regulations to provide the service. The latter refers to the actual provision of services, where implementers meet face to face with beneficiaries or service users.

The thesis aims to explain how different factors influence policy implementation. Effective policy implementation is, therefore, the dependent variable. The concept is understood here in terms of access to services and capacity to provide them. A policy is effectively implemented if access to services is extended to a wider population. This may be achieved by increasing the number of hospitals and health centres that provide the service (with the participation of private and third sector providers, for example), and/or increasing the number of beneficiaries or service users. Health care providers have the capacity to deliver the service if they have the appropriate human and material resources to do so. In the case of PHI, access to services is observed in terms of the number of people enrolled in the programme compared to the total target population. Having a low enrolment percentage may indicate there is something wrong in the implementation process. In the same way, a low relative number of providers in the programme reflect low accessibility, hence, ineffective implementation. In the case of the ILE policy, effective implementation is observed in terms of providers offering the service and number of cases treated. In addition, health care providers that do participate need to have resources, that is, trained staff,

materials and equipment, and facilities. An undersupply of resources may result in poor service delivery.

Figure 1.1 Policy implementation within the policy process



Source: Elaborated by author

The explanatory variables are the factors assumed to influence effective policy implementation. As previously explained, these variables are (i) the actors involved and their beliefs, (ii) service delivery arrangements, (iii) managerial practices in place, and (iv) citizens' participation. They have been taken from the mainstream literature on the subject of policy analysis and service delivery, particularly from frameworks suggested by international organisations like the World Bank, the IDB and the WHO (Fiszbein 2005; Stein et al. 2005; WHO 2000; World Bank 2003). This thesis argues that the values and beliefs of actors involved are the primary – but not exclusive – determinant of effective implementation. It highlights this particular factor because, in contrast to the others, it has received very little attention in the literature and so its role in implementation has been underestimated. The explanatory variables are analysed at two different levels: policy operationalisation and service delivery. This analytical distinction is useful because each level entails different actions and the interaction of different actors.

At the operationalisation level, where norms and regulations are defined and agreements are written, the main actors are politicians and administrators at different levels of government. In Mexico, the health sector is decentralised; therefore, service delivery arrangements involve central and local government coordination and provisioning. Also at this level, managerial practices include the definition and distribution of functions and responsibilities within implementing agencies; for example, the distribution of resources or the certification of service providers.

Citizens' participation in the operationalisation level means being involved in decision-making on the policy's norms and regulations, that is, the way the policy is translated into practice. Citizens may participate through advisory councils or consultations, for example.

At the service delivery level, the main actors are medical professionals who interact with service users or patients. In delivery arrangements, all three sectors – public, market and non-profit – may participate with specific contracts or independently. At this level, the managerial practices used to obtain the desired behaviour of staff are incentives and controls. This way, the desired behaviour is rewarded and undesired behaviour is punished. Regarding the delivery of services, citizens/patients/service users may get involved by participating in accountability mechanisms to hold service providers responsible for their wrong-doings. These mechanisms or channels may take the form of monitoring by CSOs, human rights commissions, complaint hotlines, or public arbitration agencies, for example.

This thesis focuses particularly on actors' ideas, values and beliefs about policies and how these may affect the implementation process. In order to take these into account, the Advocacy Coalitions Framework (ACF) offers a useful approach. According to this framework, policy actors are organised into groups or coalitions that use different resources to influence the policy process. These coalitions share the same beliefs about the policy they support and these beliefs hold the group together. It explains that, in a policy area, there are "competing" coalitions with contrasting beliefs seeking to achieve policy change in that area. The underlying premise is that actors relate to the world through "a set of perceptual filters composed of pre-existing beliefs that are difficult to alter" (Sabatier and Weible 2007). This approach is appropriate for analysing how ideas, values and beliefs determine implementers' behaviour (attitudes and actions), and the extent to which these may affect the execution of policies.

Ideas, values and beliefs

Ideas, values and beliefs are complex concepts and there is no consensus in the policy literature about their definition. They have been used in diverse ways and with different purposes (Hitlin and Piliavin 2004). These concepts are intertwined and lack clear boundaries. *Policy ideas*, *policy values* and *policy beliefs* share common elements and similar meanings in the literature. For example, Béland (2005) defines

policy ideas as “specific policy alternatives (for example, personal savings accounts) as well as the organized principles and causal beliefs in which these proposals are embedded (for example, neo-liberalism)” (p.2). Campbell (2002) refers to the same concept as “theories, conceptual models, norms, world views, frames, principled beliefs, and the like...” that affect the policy-making process (p.21). Policy values are defined along similar lines as “a set of preferred beliefs and norms, principles and practices deemed important by individual citizens” (Inoguchi 2007, p.241). Young (1979) explains that policy values “refer to policy-makers’ subjective understanding of the environment”; they are elements of “belief, perception, evaluation, and intention as responses to the reality out there” (p.33). Also, values influence behaviour, set goals and regulate conduct (Gross 1984).

For the purposes of the analytical framework presented here, a clear-cut distinction between the concepts of ideas, values and beliefs is not relevant. They are understood in terms of principles, preferred norms, and perceptual filters that determine choices and behaviour. Therefore, the analytical framework places ideas, values and beliefs on the side of independent variables. The ACF uses the term ‘policy beliefs’ to refer to beliefs about a specific policy: the way an individual believes a problem should be solved. So, for example, introducing monetary incentives based on the productivity of doctors in order to improve performance is a policy belief on the problem of underperformance by medical staff. I explain this in more detail in Chapter Two. Because of their nature, ideas and beliefs are difficult to measure. In order to observe this variable, I look for attitudes, opinions and actions of relevant actors in the policy process. These may be visible in the records of meetings, documentation, publications, press interviews as well as in my own field-interviews. Ideas, values and beliefs are expressed as attitudes and opinions that, in turn, are translated into actions. I also look for policy choices and alternatives since these also reflect values and beliefs.

Civil society and accountability

Other contested concepts used in this analytical framework are *civil society* and *accountability*. I place these concepts within the citizens’ participation variable. As with policy ideas, values and beliefs, the concepts of civil society and accountability have been used in diverse ways and with different purposes. In this thesis, I understand civil society as “the arena of uncoerced collective action around shared

interests, purposes and values.”¹⁵ Examples of CSOs are charities, nongovernmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups (op. cit). Civil society entails collective action, whereas citizens' participation may also take place at an individual basis. Within the variable of citizens' participation, I look into both collective and individual actions that have the purpose of influencing policy.

Accountability is one way to influence policy, especially service delivery. It is often cited in the literature as a key element to improve the provision of public services (Ackerman 2005; Brinkerhoff 2004; Fiszbein 2005; Goetz and Jenkins 2005; Paul 1992). For the purposes of this thesis, I understand accountability as the mechanisms through which service providers are held responsible for their performance. When collective actions have accountability purposes, that is, when civil society actors engage in these mechanisms or activities, the concept of *societal accountability* is very useful. Smulovitz and Peruzzotti (2000) define the term as “citizen action aimed at overseeing political authorities... a non-electoral, yet vertical mechanism of control that rests on the actions of a multiple array of citizen associations and movements and on the media, actions that aim at exposing governmental wrongdoing, bringing new issues onto the public agenda...” (p.147;150). This definition is suitable for the purposes of this thesis. It helps to look into the ways in which civil society may claim better service provisioning.

In summary, the framework for analysis identifies two levels in the policy implementation process: operationalisation and service delivery. Different actors and actions take place at these levels, which is useful in unpacking the factors that intervene in the process. The dependent variable is the effective implementation of policies that is observable through access to services and capacity to provide them. The framework focuses – as explanatory variables - on the actors involved and their ideas, the modes of service delivery, managerial practices, and citizens' participation and accountability. The following section explains the methods used to collect and analyse data.

¹⁵ Centre for Civil Society at the LSE,
http://www.lse.ac.uk/collections/CCS/what_is_civil_society.htm, accessed 15/07/2010

1.5 Methods for Analysis

Evidence for this research comes mainly from in-depth interviews. Newspaper articles, official documents and other online news and publications complement the information used and are used to cross-check or triangulate data. Other sources used are direct observation in hospitals and health centres and anecdotal accounts from doctors and patients. The study is, therefore, qualitative, inductive and empirical. From the close observation of case studies, the thesis arrives at more general conclusions that may offer lessons useful to politicians, policy-makers and citizens. Qualitative methods are the most appropriate for exploring and understanding processes and for considering people's perceptions and beliefs. Contrary to quantitative studies, these methods offer an insight into human action and interaction, and how people make sense of the world. Ulin, Robinson *et al.* (2004) explain that qualitative studies allow an "understanding of life in ways that consider the perspectives and experiences of people who live it" (p.4). This thesis seeks to understand the interactions among different actors and how their ideas and beliefs, as well as practices and participation in accountability mechanisms, may influence the implementation of policies.

The thesis takes the PHI programme and the ILE law as case studies to analyse how different factors influence policy implementation. The case study approach is suitable for research that seeks to have an in-depth understanding of processes. It allows for exploratory and explanatory analysis (Bryman 2004). The nature of this thesis and the issues it seeks to address call for a case study analysis. As R.K. Yin (2003) argues:

...the distinctive need for case studies arises out of the desire to understand complex social phenomena [...] the method allows investigators to retain the holistic and meaningful characteristics of real-life events –such as individual life cycles, small group behaviour, organisational and managerial processes, neighbourhood change, school performance, international relations, and the maturation of industries. (p.4)

The main questions guiding this research ask *how* and *why*, which are questions that require a deeper explanation of circumstances, causes, contexts, etc. Case study analysis is adequate to address these kinds of questions. The main criticism of this

method, and in general of qualitative methods, is about rigour, reliability and generalisation.

The rigour of qualitative studies cannot be judged using the standards for quantitative studies that are based on a positivist approach. Quantitative methods explain reality in objective and measurable terms. The accepted quality standards for this type of studies are validity, reliability, precision, and generalisability; however, these are not relevant to qualitative studies, since their purpose arises from very different perspectives and concerns. Qualitative researchers propose a corresponding but different set of standards. Ulin, Robinson *et al.* (2004) synthesise the work of several qualitative studies specialists and find four main quality standards: *credibility*, *dependability*, *confirmability*, and *transferability* (see Table 1.1). Each of these standards is comparable or equivalent to accepted quantitative studies standards, but suitable to the purposes and nature of qualitative studies.

Table 1.1 Quality standards for qualitative studies

<i>Credibility</i> (validity)	Refers to confidence in the truth of findings; it assumes an accurate understanding of the context. Findings are consistent with what they explain; they are grounded and substantiated by narrative data and interviewees may verify its accuracy.
<i>Dependability</i> (reliability)	Means that the research process is consistent and pays careful attention to rules and conventions. It sets parallels across data sources and research questions are clear and logically connected to the research design and aims.
<i>Confirmability</i> (objectivity)	Means to confirm that the data reflects as accurate as possible the interviewee's perspectives and experiences. The researcher has to maintain a distinction between personal values and those of interviewees. The researcher needs to reflect on her/his own personal values and document the role played in the research process, including biases, assumptions and reactions.
<i>Transferability</i> (generalisability)	Refers to whether conclusions are transferable to other contexts. Conceptual or theoretical generalisation rather than statistical generalisation is what matters. There is no need to be representative of a wider population.

Notes: Words in parenthesis are the equivalent to quantitative studies standards

Source: Ulin, P. R., E. T. Robinson, et al. (2005). Qualitative methods in public health a field guide for applied research. San Francisco, CA.

Following the above set of quality standards, a deeper understanding of the context is necessary in order to achieve *credibility* of findings. Prior to the fieldwork, I compiled and processed information about the characteristics of the Mexican health system so as to place the two case study policies in their wider context (Chapter Three shows this contextual framing). Having a deeper understanding of the context allows

the interpretation of findings by providing a filter and avoiding taking interview material at face value only. I also triangulated the information obtained through interviews with newspapers, documents and other interviewees' answers. Triangulation corroborates the information.

The standard of *confirmability* addresses the issue of the researcher's own perceptions and biases. Therefore, it is important to make a brief comment on my background so the reader may judge my role as researcher. During the course of this research, and especially during fieldwork, I went through a personal and inner reflection about my own values and perceptions about the issues I was enquiring into. I grew up in Mexico within a Catholic family and studied in religious schools until I was 15 years old. That had a deep impact on the formation of my values and beliefs. However, like many teenagers, I started questioning most of those "imposed" beliefs – for me, they were imposed by family and society. During university studies, I became more "open-minded", interested, respectful and receptive of different ideas and values.

I have now been living in the UK for the past eight years. Being away from my family and society, I built my own set of ideas and values. I had, indeed, broken patterns and expected paths for a woman in the society I grew up in. I see myself now as an "outlier" of that rather conservative society. When I started this study I did not have a strong position towards the Popular Health Insurance or abortion. This "ambiguity" benefited the study, especially during fieldwork, because I was able to talk to both opponents and supporters with equal empathy. This was very useful during the interviewing process. However, later in the research I was unable to avoid feeling a strong sense of disagreement with some of the views that anti-abortion medical doctors expressed in my interviews with them; ideas such as "abortion could only be accepted in cases of rape of *niñas mongolitas* (a derogatory way to refer to girls with Down's syndrome)", or "those kind of women don't come to our hospital" referring to women seeking an abortion. On the contrary, I found a very coherent discourse in the advocates for women's choice and sexual rights. In the case of PHI, by having a deeper understanding of the policy I can see both positive and negative aspects in it. I agree with some of the ideas that support it, but I also agree with some of the opposing social medicine values. During fieldwork, I was able to see some of the benefits of the PHI, as well as some of the concentration of power that undermines it.

Finally, *dependability* requires an adequate use of data sources. The main source of information was in-depth interviews, but I also used official documents, reports, websites, newspapers, and court proceedings to triangulate information.

In-depth interviews

I carried out a total of 63 face-to-face interviews from March to May 2008 and during January 2009. All interviews were conducted in Mexico City. Interviewees are grouped according to four categories: academics, government officials, NGO directors, and service providers (see Table 1.2). The purpose of interviewing academics was to get a better understanding of current issues being discussed in the literature, as well as to assist in identifying key informants. Government officials involved in policy implementation were interviewed in order to understand the kind of issues they faced when starting and performing operations, as well as the nature of their relationships with service providers. Interviews with NGO directors that work in the relevant policy areas were carried out to identify their views and perceptions of the policies and their relationship with government agencies or other official actors, such as advisory committees. Finally, the purpose of interviewing service providers was to understand the problems or obstacles in delivering services on a day-to-day basis, as well as their relationship with administrators, beneficiaries and other providers.

The selection of interviewees was done in two ways: individual selection and purposive or strategic sampling. Academics and government officials were selected according to their specialisation and position held. I started by identifying health policy specialists from the Mexican academic community. Most of them are based at the National Institute of Public Health (INSP) and the Autonomous Metropolitan University (UAM). I interviewed six academics that provided an overview of the context and the issues in the debate around the two policies. After a round of interviews with academics, I mapped out key governmental actors involved in the implementation of the PHI policy and the ILE law. The experience of these actors, directly involved in carrying out the policies under study, is unique and fundamental for the research. I interviewed individuals in public health agencies at both federal and local governments, which explains why they had to be individually selected. The PHI programme started operations under previous administrations; therefore, I interviewed the former Minister of Health, who was in charge of extending the programme to all

states, and the former Secretary of Health in Mexico City, who was in office when the Popular Health Insurance was introduced in this city. Other key actors interviewed were the former and the current coordinator of the PHI at the local level, as well as members of the national coordinating body. Directors and administrators in the Mexico City Health Department were interviewed about their role in carrying out and overseeing the ILE law. In total, twelve government officials holding key positions for both policies were interviewed once or twice. Government officials, such as politicians and administrators, gave their opinions (views and perceptions) about the policies, and described the problems they have (or had) in operating the programmes. NGO directors were also selected on an individual basis. I identified influential organisations within the two policy areas under study. By influential, I mean that they actively participated in policy debates and advocacy or were involved in service delivery. There were only a few NGOs with these characteristics. I interviewed those organisations that granted an interview – in some cases, the requested interview was not given even after several phone calls and emails. All of the above interviewees were treated as key informants; therefore, questions were adapted during the interview according to emerging issues. I explain the interview methods used below.

The process of selecting service providers was different from that used to select interviewees. I followed a purposive or theoretical sampling method. This selection of interviewees is not, and does not, pretend to be statistically representative of the universe; rather, it is a strategic selection of cases (Johnson and Reynolds 2005), where the presence or absence of characteristics that are important for the study is the main selection principle. Strauss and Corbin (1998) explain that theoretical sampling is guided by analytic and theoretical purposes in order to find varying dimensions, strategies, and so on. I interviewed public service providers (hospitals and health centres) that participated in both policies. By doing so, I was able to ask about the two cases in one interview. Two federal public hospitals not offering abortion services were also included in the sample because their views and opinions are relevant. The fact that hospitals of this type were not participating has implications for policy implementation in terms of service accessibility. Most local public hospitals participate in both policies; therefore, hospitals were selected in different areas of the city to maximise opportunities for discovering different issues. I interviewed 17 individuals in 13 health establishments in total, stopping the process when data saturation was achieved. According to Bryman (2004), data saturation

means that no new relevant data emerge in additional interviews and the relationships among categories is well-established and validated (p.305).

I also interviewed private and third sector service providers to enquire about the reasons and experiences for participating – or not – in delivering services. Sampling for these types of providers was also theoretical. However, it was more difficult since the sector of private and non-profit health providers in Mexico City is significantly bigger and far less known than public providers. I selected private and non-profit providers from official lists of health care establishments held by the Ministry of Health. To illustrate the different kinds of establishments that are characteristic of the private sector, I interviewed one large hospital (a member of a national health conglomerate), one medium-size hospital and two small clinics. In the third sector, I followed the same rationale and selected establishments that best illustrate the sector in the relevant policy areas: one faith-based and one secular providers of primary health care, and one secular provider specialising in reproductive and sexual health.

Questions were designed according to interviewee category. I used two kinds of interview techniques: elite and specialised interviewing.¹⁶ Manheim, Rich *et al.* (2001) explain that elite interviewing is adequate if the interviewee requires individualised treatment, that is, they require a unique rather than standard set of questions. This is useful for key informants that are specific individuals because of their current position, trajectory, or knowledge. In this case, the individuals involved in the decision-making over the implementation of policies required a specific set of questions referring to their perceptions, participation and experience. I used elite interviewing for academics, government officials and NGO directors. For service providers, I used specialised interviewing. The same authors explain that this type of interview is adequate for interviewees that are representative or typical of some particular group within a population. In this case, medical staff and hospital directors interviewed are representative of this population group. I adapted the questions according to the type of provider (public, private, non-profit) and also whether they were participating in the policies under study. This allowed particularities to emerge (see Table 1.2).

¹⁶ A thematic guide for interviews is included in the Appendices.

Table 1.2 Types and number of interviews carried out

ELITE INTERVIEWS		SPECIALISED INTERVIEWS		
		Services providers	Individuals	Establishments
Academics	6	Private	9	8
Government	12	Public	17	13
Civil Society	8	NGO	8	3
Service Providers	3			
Subtotal	29	Subtotal	34	24
TOTAL INTERVIEWS	63			

Institutional materials and publications

These materials and publications are produced institutionally, for dissemination or normative purposes. They mainly include policy guidelines and norms, but also numbers and figures relating to the implementation of the policies, for example, coverage, affiliation, budget, and so on. In the case of NGOs, these materials provide an overview of their work, their objectives and projects. The materials considered were produced between 2001 and 2009.

Websites

The Internet provides an efficient way to access information. The websites of most institutional actors, like the Ministry of Health, the Mexico City Health Department, hospitals, NGOs, and research institutions, provide information that I used to design elite interviews. Also, I accessed online databases for statistical data on health coverage, use of services, health expenditure, and so on.

Local newspapers

Since both policies have been at the centre of the public debate at some point in time, local newspapers provided information about the reaction of the public and specific actors about the policies observed. The newspapers I consulted the most are *Reforma*, one of the most widely-read newspapers in the country; *El Universal*, a centre-right newspaper; and *La Jornada*, with a leftist approach. This way, I kept a balance on the political views of newspapers. This was a useful way to track different beliefs, attitudes and values. The dates of newspapers considered ranged from 1994 to 2011.

Legal documents

These comprise the bills and reforms of existing laws that allowed the creation of the PHI and the ILE policies. They include the norms and regulations for implementation by public institutions. I also used Supreme Court official documents on constitutional controversy resolutions. These provided a good source of actors' ideas, values and opinions on the policies.

Transcripts of public audiences and deliberation proceedings

These materials include national and local legislature transcripts of plenary sessions on debates about the policies under study. Also included are text documents presented to the Supreme Court during public audiences about the constitutionality of the ILE law in Mexico City. As with the above, they were a good source of ideas and opinions of policy supporters and opponents.

Data Analysis

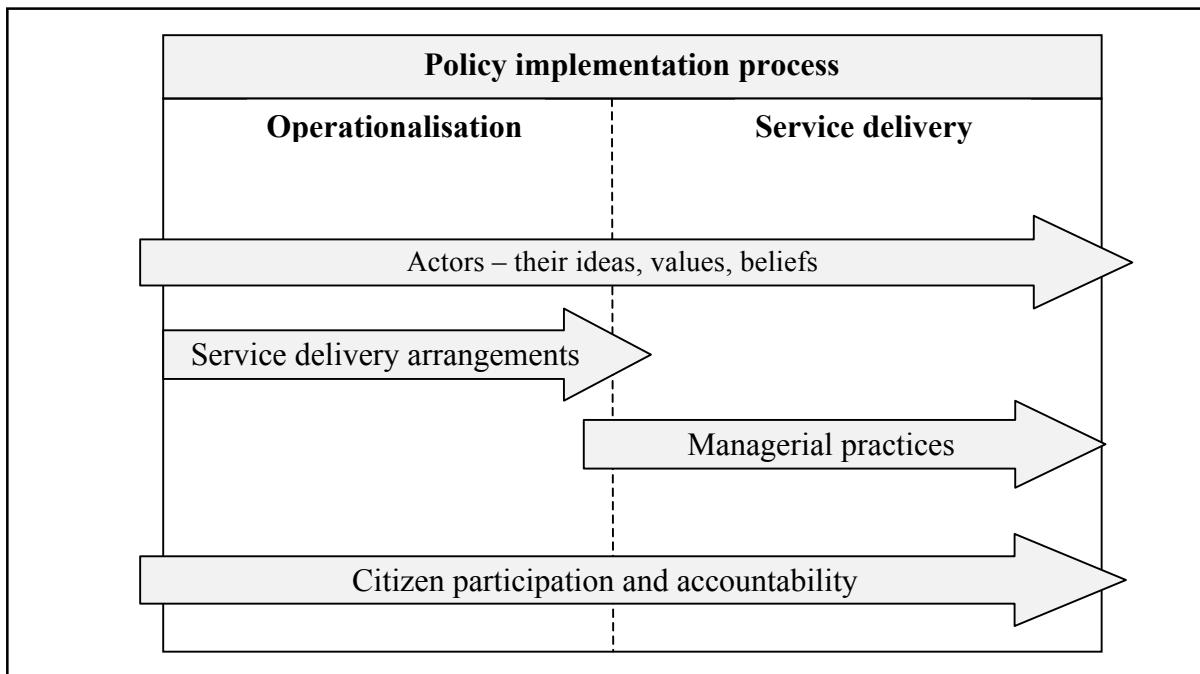
Most interviews were recorded and transcribed. In some cases, interviewees asked not to be recorded. In other cases, I preferred not to bring the recorder so the interviewee would not feel restricted in expanding upon answers, especially with regard to sensitive topics such as abortion. In these cases, I transcribed the notes I took during and after the interview. I suggested to interviewees that I could preserve their anonymity when writing up so as to ensure they would feel comfortable in the interview and feel free to talk; however, most of them did not seem to be concerned about their names being cited. Transcriptions were coded using NVIVO 8 software for qualitative analysis. Data from document materials were manually coded by matching categories used in the software. Coding of documents and transcriptions followed the dependent variables of the analytical framework: actors and their beliefs, delivery arrangements, management, and citizens' participation.

During the analysis, I mapped main actors, such as politicians and key administrators, as well as governmental agencies, NGOs and private service providers; I included a profile with their characteristics (size, position in health system and level of government) and, in the case of people, their values and beliefs. In order to observe personal ideas, values and beliefs, I asked for opinions and looked for behaviours such as decisions, actions, practices, attitudes (Ulin et al. 2004). In

addition, institutional documents, legal proceedings, and public audience materials contain statements that reflect the ideas and values of the actor in question. The same analysis was made for street-level providers in order to grasp their values and beliefs in respect of the policies under study. Finding information on delivery arrangements was more straightforward and included looking for contracts and agreements between federal and local levels of governments, and between governments and private and non-profit providers. For managerial practices, I asked about the use of financial resources (that is, who decides how to use them), degree of autonomy from superiors, mechanisms for controlling services (that is, checking diagnoses and patients' files), incentives for rewarding or punishing staff behaviour, and monitoring performance through mechanisms such as complaints boxes and hotlines. Finally, to find out about citizens' participation, I interviewed civil society actors engaged in the implementation process (in public complaints bureaus, advisory boards, and human rights commissions/ombudsmen or women).

The analytical framework (see Figure 1.2), as explained before, establishes a degree of causality between independent and dependent variables. Causality is judged in qualitative terms rather than by the use of indicators. Through the analysis, I observed *how* each variable influenced effective policy implementation in terms of access to services and capacity to provide them. Variables affect policy implementation in different ways. In order to determine which are more relevant or have a greater influence than others, I observed *how* they affected implementation. There is a logical degree of affecting implementation: if a variable completely obstructs the process, it has a greater impact or is more relevant than others that do not obstruct implementation (even though they might also constraint it). Other degrees of impact are determined by the way in which the variable influences effective implementation – in access or in capacity to provide policy services. Access to services is perceived as having a higher importance. Restricted or no access to health care services means there is no policy implementation, whereas having access to a poor service (low capacity to deliver) means implementation can and should be improved. Therefore, if a variable affects access to services it is more relevant than others that affect providers' capacity. Empirical chapters of the thesis explain how variables influence policy implementation.

Figure 1.2 Analytical Framework



Source: Elaborated by author

1.6 Organisation of the thesis

This thesis is divided into seven chapters, each addressing a set of issues related to the main research question about the factors that affect the effective implementation of health policies.

Chapter 2

This chapter addresses the theories that are relevant for the thesis. I construct a theoretical framework by employing useful elements of theories in the study of health policy implementation. I use the ACF to identify the main actors involved in policy-making. This analysis is important in order to understand the position and the role of actors in the implementation process. The chapter draws on the literature on implementation studies and the policy process to explain how policies are carried out. From theories of democracy, I use the participatory approach to explain the interaction between the state and civil society on issues related to service delivery.

Chapter 3

Chapter three analyses the context of the study, the profile of service providers and explains the case study policies in more detail. The aim is to provide an overview of the Mexican health system in order to understand how the health sector's different components are integrated and how they operate; the chapter does not, however, evaluate its performance or efficiency. I discuss what a health system is, and continue with how the Mexican health system is organised, its different elements, functions and main actors. I explain the recent reforms that have been transforming the health sector in the country and shaping health care services delivery modes. This chapter serves as a base by which to understand the case study's health policies' scope and extent, and the different health care providers involved in the policy processes.

Chapter 4

Chapter four identifies the main actors that support the policies under investigation in order to see how they influence implementation. The aim is to provide an analysis of the actors involved in bringing the issues to the public agenda and achieving policy change. Following the ACF, I focus on the policy beliefs of social and political actors involved in the policy process. The chapter explains the configuration of advocacy coalitions that have influenced the adoption of the two case study policies, the way they work, their resources and main characteristics. Within each policy area, I identify one dominant coalition and its competing counterpart. Each coalition holds a set of common policy beliefs expressed through their proposals and advocacy activities.

Chapter 5

Chapter five looks at how policies are translated into action. It addresses service delivery arrangements and the actors involved. It focuses on the operationalisation level of policy implementation and analyses the relationships between the federal and the local governments. The chapter also explains the degree of participation of the private and third sectors and the reasons to participate or not in providing policy services.

Chapter 6

This chapter examines managerial practices used by implementing agencies and service providers. It focuses on the service delivery level of policy implementation and looks at the attitudes and beliefs of those at the front line of service delivery. The chapter analyses the impact of values and beliefs on the effective implementation of health policies.

Chapter 7

Chapter seven addresses the issue of citizen participation and accountability in improving service delivery. It analyses the ways in which citizens relate to the state in order to influence policy implementation in the health sector. In the Mexico City context, I look into the available mechanisms that citizens have to make their voices heard by authorities. I also look into civil society-government interactions such as advisory councils and public-private partnerships. The aim is to better understand the institutional channels that citizens have to express dissatisfaction with public services, and to what extent these spaces are effective in influencing policy implementation. I also explain the role of medical professional associations, as key civil society actors, and their involvement in shaping health policies.

Chapter 8

The final chapter draws together the key findings of the thesis and relates these to the original research questions and hypotheses. It discusses the empirical and theoretical implications of these research findings. It also explains their meaning to policy implementation studies and other theories addressed here. This chapter offers some policy recommendations and identifies relevant issues for future research.

2 Theoretical framework

How are health policies put into practice? What factors influence the effective implementation of policies? The research questions guiding this thesis cannot be usefully answered without first establishing a theoretical framework that can explain how policies are effectively implemented. The aim of this chapter is to present a framework appropriate to the aims of this thesis, explaining the different theoretical perspectives it adopts and reviewing other relevant theories. In doing so, the choice of specific variables for observation becomes clear.

For this thesis, effective implementation of health policies is understood in terms of extending *access* to services, by increasing the number of providers (including private and non-profit providers), and the *capacity* to deliver services (having appropriate resources). This chapter reviews theories of the policy process, and goes on to give an overview of research on policy implementation since these are the two central concerns of the thesis. To complete the framework, literature on service delivery and contemporary theories of social policy are addressed, such as “new public management” and “participatory democracy”. These theories shed light on the relevant variables that may influence policy implementation.

The first sub-question in the thesis asks about the actors involved in advocating and implementing policies, and how their ideas, values and beliefs may affect this process. To map key actors, I use the ACF that gives particular attention to actors’ ideas and beliefs about policies and how these policy beliefs hold coalitions together. This theoretical framework is useful because, by identifying coalitions and understanding how they work, it is easier to observe their influence on policy implementation. To complement the perspective on actors’ ideas, values and beliefs, I also investigate and draw on useful elements of other theories that address belief systems within policy studies.

The second sub-question enquires about managerial practices, as well as about the modes of service delivery, that is, how the service is actually being provided to the population: through decentralised services, concessions, contracting-out, and so on.

Most of the literature addressing service delivery modes examines the quality of social policy outcomes under various circumstances.

This thesis is not concerned with evaluating the impact of policy services, but with understanding how they are provided. It is concerned with extending access to services; therefore, the participation of private and non-profit providers is important to observe. Regarding management practices in policy implementation, the theoretical framework draws on the NPM approach to understand why managerial practices are important and how they may be observed in implementing agencies.

To explain the relevance of citizens' participation in policy processes (the final sub-question), the framework builds on the "participatory democracy" theory. Scholars of this theory argue that ordinary people or citizens must have a say in the issues that affect their lives. Hence, citizens should be involved in policy decision-making. This theory provides a basis for looking at how citizens may influence implementation processes. In order to understand how citizens can hold service providers into account, the thesis takes stock of approaches that observe collective actions such as the "new democratic spaces" and "societal accountability" approaches. Even though these theoretical frameworks are not specifically related to policy implementation, they are appealing because they combine the idea of civil society with real actions that aim to influence public concerns like health policies.

2.1 The public policy process and implementation studies

Policy studies are essentially about politics, but they also draw on other social sciences like psychology, sociology, public administration and economics. One of the main pillars of policy studies is Lasswell's model of the political process. He is concerned essentially with "who gets what, when and how" and argues that political processes involve *participants* with a set of demands, expectations and values who interact in *arenas* where decisions are taken, and employ *strategies* to win indulgences over deprivations, and to influence outcomes and effects (cited in Parsons 1995, p.339). For Lasswell, politics is a process of negotiation and influence. Lasswell is considered a pioneer of policy studies and, some argue, his works marked the development of the field.

There is no firm academic consensus on the definition of "public policy", nor is there a singular approach to the analysis of policy. Regarding the issue of

definition, Jenkins, for example, defines policy as a “set of interrelated decisions [...] concerning the selection of goals and the means of achieving them within a specified situation” (1978, p.85). Heclo (1974a) puts the emphasis on the course of action or inaction rather than on the decisions. Dye (1984), for example, understands public policy as “whatever governments choose to do or not to do” (cited in Fischer 2003, p.2). Research for this thesis looks at the importance of both decisions and actions. Therefore, public policy is understood here as a course of action or inaction taken by the state that involves making decisions about goals, means and ends and may also include the involvement of nongovernmental actors. This definition is suitable for the two case study policies examined in Mexico City: the PHI programme and the ILE law.

Having clarified the definition of public policy used in this thesis, it is important also to discuss two basic approaches within policy studies. The first approach is about the analysis *of* the policy process, and the second is about analysis *for* the policy process. The first refers to understanding how a problem is defined, the choices made by actors in the course of working to tackle the problem, how these actions take effect and an evaluation of these actions. The other division of policy studies has to do with generating knowledge about a problem and how to solve it. Therefore, the first looks at the process and the second looks at actual policy content. In this thesis, I analyse the implementation processes of two health policies in order to understand the factors influencing those processes; the contents of the health policies observed are not subject to analysis or judgement about their appropriateness.

Several trends or schools of policy analysis studies have developed during the past few decades. Bobrow and Dryzek (1987) identify five main theoretical frameworks: welfare economics, public choice, social structure, information processing, and political philosophy. Parsons (1995) adds three more categories: political process, comparative politics, and management. These frameworks illustrate the multidisciplinary character of policy studies.

Perhaps one of the most well-known approaches to policy analysis is the “stagist” approach. In order to facilitate the understanding of policy processes, this approach divides the process into a set of phases or steps, from setting the agenda (defining the problem), to policy design (deciding how to tackle the problem), to implementation, and finally to evaluation. It is very common to find this stage division in policy process textbooks, as it offers a clear differentiation of the issues

and factors involved in each stage or set of activities. However, some policy scholars have strongly criticised this approach (deLeon 1999; Sabatier 2007). The main criticism is that a sequence of stages limits the depth of analysis; stages are not clearcut in the real world, as they overlap or simply do not have clear boundaries; decisions are taken throughout the process and not only during policy design as suggested. Despite such criticisms, the stagist approach is still widely used.

By focusing on policy implementation, the thesis implicitly adopts the stagist approach. Although I agree with its critics, the stagist approach helps to easily identify the issues and activities involved in the discrete parts of the process that I am interested in observing. The approach may consequently be seen as a useful analytical tool rather than as a comprehensive causal theoretical model. It is recognised that policies are still being shaped and redesigned during implementation, even though the policy “design stage” would have finished long before the “implementation stage”.

In spite of the diverse range of theoretical frameworks cited above, the policy studies field does have two fundamental disciplinary roots: economics and politics. Frameworks within a neoclassical economics perspective, like welfare economics, public/rational choice, economic institutionalism and, to some extent management, assume a model of the individual that is rational and self-interested, often known as “homo-economicus”. On the contrary, political science models of policy studies consider human behaviour as complex and involving power relations, values, interests, compromises, adaptation, and so on. Economic approaches give less attention to personal ideas, values and beliefs.

The model of the individual is a basic and underlying assumption of theoretical frameworks. It embodies the classic debate between political and economic sciences. Neoclassical economics assumes that individuals are motivated by material self-interest and are utility-maximisers. Economics focuses on translating this into monetary or numerical values. On the other hand, politics assumes that individuals’ motivations are influenced by contextual/environmental factors, power relations, and cognitive processes. Therefore, the theoretical framework of this thesis is based on a political model of the individual and stresses the role of ideas, values and beliefs as key motivations of individuals’ actions and behaviour. This assumption is a fundamental aspect to look for when reviewing different theoretical approaches to policy analysis. Economics and rational choice approaches encompass individuals’ motivations and behaviour in a utility function that captures the relative weights to

each variable in terms of levels of satisfaction. The function may include preferences based on ideas and values; however, it does not explain *how* those ideas are formed or their potential to compromise. The function takes preferences for granted.

The political model of the individual used in this study builds on Steven Lukes' definition of power. He identifies three views on the concept: one-dimensional, two-dimensional and three-dimensional. The one-dimensional view "involves a focus on behaviour in the making of decisions on issues over which there is an observable conflict of (subjective) interests, seen as express policy preferences, revealed by political participation" (Lukes 2005, p.19). The other two- and three-dimensional views consider a degree of non-decision making, that is, those potential issues that are kept out of politics. In this thesis, however, the focus is on actual behaviour and express policy preferences. That is why the one-dimensional view of power is more suitable for this study.

In policy analysis, new institutional economics and institutional rational choice are frameworks that follow a neoclassical economics model. Rational choice is defined here as the application of economic principles and analysis to political issues; this approach has been very influential in more recent years. In this perspective, public policies are understood as institutional arrangements and actors are guided by policy preferences and perceptions of expected benefits. Elinor Ostrom has been largely responsible for the construction of the institutional analysis and development framework (IAD), which is based on the rational choice paradigm. In the IAD framework, institutions are defined as "shared concepts used by humans in repetitive situations organised by rules, norms, and strategies" (Ostrom 2007, p.23). Behaviour is determined by institutional arrangements, attributes of the physical and material world, and by the characteristics of the community where institutions develop. The IAD, however, has a more nuanced concept of the individual to that used in neoclassical economics or rational choice theory. Instead of assuming that actors have complete and ordered preferences and perfect information, and that they maximise the net value of expected returns, the IAD assumes that individuals are fallible and have a capacity to learn from experiences. As Ostrom explains, a model of the individual based on "bounded rationality" assumes that "persons are intendedly rational but limited so". They make mistakes in the calculation of expected benefits and costs because information is incomplete and they have imperfect information-processing capabilities. However, individuals are capable of learning over time and gain a greater

understanding and higher returns (Ostrom 2007, pp.31-32). For policy analysis, this framework implies a focus on institutions but neglects the influence of personal values and beliefs. It assumes that individuals seek to maximise their benefits but may fail to do so. The analysis of actors involved in policy processes, therefore, assumes that all of them would behave according to the institutions and context where they act.

Other institution-based frameworks, like historical, political and sociological institutionalism, are important in highlighting the impact and the relevance of “cultures” or institutions on human behaviour (March and Olsen 1989; Skocpol 2003). They consider ideas and values in these frameworks, but these are found in the institutions themselves rather than in the individual. These approaches do not explain how institutions interact with personal ideas, values and beliefs, or how ideas and values outside the institution may result in different behaviours.

Different frameworks of policy analysis focus on different issues simply because they try to answer different questions. For example, the “punctuated-equilibrium” theory focuses on agenda-setting and issue definition (Goertz 2003; Repetto 2006). It, too, is based on political institutions and bounded rationality decision-making. It explains policy changes as the interaction of multi-level political institutions and behavioural decisions that create patterns of stability and mobilisation (True et al. 2007). The multiple streams framework associated with Zahariadis (1995, 2003, 2007) explains how policies are made by national governments under conditions of “ambiguity”. It also focuses on agenda-setting and decision-making and looks at the search for alternative policy instruments and the adoption of certain alternatives over others. This framework argues that a policy system is comprised of three independent “policy streams”, namely problems, policies, and politics, and that windows of opportunity open at critical points in time when the three streams come together. Policy-makers adopt a policy only if all three streams come together in a single package (Zahariadis 2007).

Other frameworks have a different perspective on agenda-setting and problem definition. The social construction framework supported by policy scholars, like Ingram and De Leon (2007), argues that social problems are not neutral or objective phenomena but are subjectively defined as problematic. Hence, problem definition is a political exercise based on values. The framework looks at the social construction of target populations, that is, the definition of policy beneficiaries. It seeks to answer why benefits are distributed the way they are among the population. This approach is

based on interpretation and the subjectivity of policy-makers in determining target populations (Ingram et al. 2007).

In reaction to positivist frameworks, the self-labelled “postmodern” approaches have emerged to provide an alternative perspective in policy analysis. These focus on ideas, meanings and interpretation. The policy process is understood as the struggle for the determination of meaning (Yanow 1996). As Fisher (2003) explains, ideas shape how actors see and change their interests. These approaches look at how ideas define the problems set by governments and assume that political action is influenced by ideologically-shaped discourses. They argue against the homo-economicus model by stressing that self-interest is unable to explain important changes in behaviour. The most commonly used analytical tool of postmodern theorists is discourse analysis. For postmodernists, narratives and story lines and the discursive practices they engender drive institutional practices and advocacy argumentation processes (Hajer and Wagenaar 2003). Within this set of approaches, the deliberative governance framework focuses on the relationship between policy adviser and politician, highlighting a process of deliberation in finding a “better argument”. Similarly, the democratic deliberative policy approach argues that “citizen participation in the policy process can contribute to the legitimization of policy development and implementation” (Fischer 2003, p.205).

Other approaches are the pluralist-elitist and the networks frameworks. The pluralist-elitist approach focuses on the distribution of power and how this affects policy-making. The networks approach looks at how interest groups outside and inside the state relate to each other and how they influence the policy process. The former focuses on decision-making, that is who takes policy decisions and how; the latter focuses on patterns of formal and informal contacts and relationships (Parsons 1995). The networks framework explains policy-making in policy domain-specific sub-systems, where a large number of actors deal with specific policy issues. Policy sub-systems are characterised by public-private interactions. One of its central assumptions is that actors are dependent on each other because they need each other's resources to achieve goals. Policy networks are defined as stable relationships between actors with regular communication and frequent exchange of information and mutual interests. The speed and extent of policy change is then influenced by a network's capacities. This approach is very interesting, since it not only focuses on

actors but also on their interaction (Adam and Kriesi 2007). Among the network approaches is the ACF, which I use here to analyse policy actors and their beliefs.

Delimiting implementation analysis

The field of implementation studies is a sub-discipline of the wider field of public policy analysis. It focuses on how policies are put into practice. This stage of the policy process is easier to identify in political systems that require a level of formality to policy-making. For example, within legislative systems that enact policies after a period of negotiation, policy implementation starts with the publication of the policy and the definition of roles of implementing agencies. Hence, agenda-setting and policy design precede enactment, while policy implementation follows it. Taking into account the view put forward by Sabatier and Jenkins-Smith (1993), implementation is an on-going part of the policy-making process where decisions are taken and policy is formulated. Policy design influences implementation and, conversely, during implementation a policy is usually redesigned; policies are shaped during implementation. In order to understand the dynamics of the implementation processes, the analysis has to focus on the actual carrying out of the policy and leave out processes of agenda-setting and policy choices. A vast literature on the implementation stage shows the relevance of understanding how policies are translated into actions, as this in turn affects policy outcomes. In this section, I will focus on the implementation studies literature.

The study of implementation is about analysing the interplay of politicians, administrators and service providers. There are different definitions of the term “implementation” in the literature; however, far from excluding each other, their core differences lie mainly in the variables they focus on. Howlett and Ramesh (2003), for example, define implementation as “the process whereby programmes or policies are carried out, the translation of plans into practice” (p.185). O’Toole (2000) understands it as “what happens between the establishment of a policy and its impact in the world of action” (p.273). These authors focus on processes and actions taking place after a policy has been enacted. Others, like Mazmanian and Sabatier (1981), emphasise the role of decision-making, first when addressing a problem, then within the implementing agencies, and finally in the compliance of target groups. Other definitions focus on concepts such as pragmatisation (Dunsire 1978), for example what happens when policy intentions are turned into action (John 1998), the expected

versus the achieved (deLeon 1999) and the interaction and negotiation processes (Barrett and Fudge 1981), among the most relevant applications of such an approach.

The definition I use for implementation draws on elements of the above perspectives to highlight the most relevant aspects to look at when studying implementation. In this thesis, implementation is defined as a process that takes place between policy design and its observed results or impacts. It includes decisions and interactions among different actors. Implementation cannot be fully understood without looking also at the influence of policy design processes on implementation and the underlying values and beliefs of actors associated with the policy itself. In order to facilitate the analysis and interaction of actors, I identify two levels in the process of implementation: policy operationalisation and service delivery. Policy operationalisation refers to the negotiation and determination by government officials and managers of the rules and procedures to put the policy into action. Service delivery refers to the provision of services, including actions by street-level implementers and their interaction with policy beneficiaries.

Overview of implementation research

Public policy processes have been widely studied, from setting a policy agenda to policy evaluation. Early studies of public policy were concerned with inputs and outputs; they focused on the resources needed to achieve predefined goals and did not consider the influence of bureaucracy and service providers on the effectiveness of a policy (Parsons 1995). It was not until the works of Pressman and Wildavsky (1973) that attention turned specifically to policy implementation,¹⁷ for example, what happened inside the black box, between goals and actual results. They were concerned about policies failing to achieve their aims and put the blame not on bad design or poor evaluation, but on those in charge of carrying them out. This opened up research opportunities in a somewhat underexplored terrain. Hargrove (1975) labelled policy implementation as the “missing link” because it had been so neglected by policy analysts.

From the time of this call for a deeper understanding of policy implementation, a vast literature has been created exploring it. And yet, there is still no consensus among academics or practitioners about the factors that facilitate or constrain the

¹⁷ As Hill and Hupe (2002) point out, implementation studies were also carried out before Pressman and Wildavsky’s seminal work, but it was framed under a different name.

implementation of public policies. Implementation continues to be the missing link (Robichau and Lynn 2009).

Three generations or waves of implementation studies have been broadly identified and accepted (Fischer et al. 2007; Goggin et al. 1990; M. Hill and Hupe 2006; Howlett and Ramesh 2003). The first generation is best illustrated by the works of Pressman and Wildavsky (1973), who stress the need to scientifically explain why policies were not delivering the expected results. The relevance of the first generation rests mainly in its effort to simply widen the scope of policy analysis to the implementation phase. The second generation is dominated by a debate between the so-called top-down and bottom-up approaches, which take opposite analytical focuses about the implementation process. The subsequent wave of studies – the third generation - aims to reconcile these approaches and suggest different analytical stands.

“Top-down” approaches, also called “rational control models”, see implementation as a logical sequence or chain of activities (Pressman and Wildavsky 1973). If implementation fails, top-down scholars argue, it is because the strategy or instruments were wrongly selected, operationalisation was poor, or there was an inadequate response to problems. For these models, what matters for effective implementation is command and control, making sure that instructions are obeyed throughout the chain (Gunn 1978 cited in Parsons 1995). They place a central role on decisions made by politicians and see implementation as the follow-up of those decisions by administrators and service providers. Hill and Hupe (2002) phrase this as the “implementation follows formulation and decision theorem” (p.4). For example, Van Meter and Van Horn (1975), classic authors of this approach, highlight the role of decision-making processes by those at the top and see implementation as an administrative process. Implementation failure is about poor management and communication (Hood 1976).

The main criticism of the top-down view is its neglect of the influence that actors within the process have on the effectiveness of implementation. That top-down view disregards the ideologies, values, beliefs and motivations of implementers (Dunsire 1990 in Pütlz and Treib 2007). In response, the “bottom-up” literature focuses on human interaction among actors involved in the implementation process and those affected by the policy. According to the bottom-up approach, implementers should be considered in behavioural terms rather than as elements in lines of

command (Elmore 1979). Lipsky's (1980) work on street-level bureaucrats is the classic example of the bottom-up approach. He argues that bureaucrats in charge of delivering services possess a great deal of discretion in their actions and behaviour, giving them a degree of power to amend or even change policies. Barrett and Fudge (1981) build on this idea and argue that actors operating a policy inevitably interpret it and modify it, hence making decisions – and, therefore, policy – during the implementation stage. For the bottom-up approach, effective implementation is therefore determined mainly by the knowledge and experience of people in the front-line of service delivery (Parsons 1995, p.470).

The third generation of implementation studies encompasses “hybrid theories” that bring together elements of both top-down and bottom-up literature in search of a more comprehensive approach to the subject (Parsons 1995). This development was led by eminent scholars like Wildavsky, Sabatier and Elmore, who modified their initial top-down or bottom-up perspectives. For example, Elmore (1985 in Parsons 1995) developed the concept of “forward mapping” to complement his previous “backward mapping” analysis, where he suggests first taking into consideration the dynamics of implementers and target groups and then moving up to policy-makers. Majone and Wildavsky (1978), Browne and Wildavsky (1984) Heclo (1974b), Bennett and Howlett (1992), Sabatier and Jenkins-Smith (1993) all modified their understanding of implementation to a learning or evolutionary process, where actors take their experience of feedback into the process and adapt it to deliver better results (Fischer 2003; Parsons 1995). Lowi (1972) identifies “policy types”, namely distributive, regulatory and redistributive, and suggests looking at different factors influencing implementation according to the policy type. The top-down/bottom-up debate was eventually overcome when policy scholars acknowledged the value of different theories and frameworks in bringing different perspectives to understanding the implementation process rather than validating one approach over another (Elmore 1979; M. J. Hill and Hupe 2002; Parsons 1995).

One of the most recent contributions to the study of implementation takes the concept of “governance” as a base. Scholars like Hill and Hupe (2002), Meier (2003) and Robichau and Lynn (2009) put forward a model of governance for implementation studies building on a managerial approach and incorporating elements of political science. The focus is on governance that refers “to the way in which collective impacts are produced in a social system” (M. J. Hill and Hupe 2002, p.13).

The model identifies multiple levels of action and different variables that influence performance such as citizen preferences, public choice and policy designs, public management, service delivery, outputs and outcomes (Robichau and Lynn 2009, p.23).

Though much has been written about what makes for effective implementation, there is still no consensus about what works best under which circumstances. The different approaches and theories on the issue offer a partial view of facts - or, as Allison (1971) puts, it, "they offer different lenses to look into policy processes focusing on some elements while blurring others". Policy analysis, especially the field of implementation studies, needs more dialogue within itself in order to construct a better understanding of relevant issues.

For the purpose of this thesis, several of the perspectives described above are adopted for the study of policy implementation. Processes are observed from the top (operationalisation level) and from the bottom (service delivery level). Actors at all levels are considered, from politicians to street-level practitioners. The thesis is also concerned with the influence of ideas and beliefs on implementation and, therefore, draws on the ideas of post-modernist theorists. To include more recent and mainstream approaches, the thesis framework also looks at managerial practices. By analysing two policies that involve service delivery, the thesis bridges the policy literature with the service delivery literature¹⁸ and looks into how services are actually provided to the population. The service delivery literature often includes citizens' participation as a desirable feature to improve providers' performance. Following the literature on participatory democracy, this thesis adds into the analysis the role of citizens' participation in policy processes, therefore bringing this dimension to the study of implementation. The following sections review the relevant theories that deal with the factors this thesis observes.

2.2 Policy Actors and Advocacy Coalitions

The ACF developed by Paul Sabatier and colleagues since the late 1980s, offers a suitable approach for analysing the different actors involved in policy processes. The main component of the ACF that serves the purposes of this thesis is its model of the

¹⁸ Although policy implementation does not always imply service provisioning.

individual. Contrary to rational choice theories, the framework's model is centred on belief systems rather than material self-interest. These systems are what form the basis of coalitions in a specific policy area. The framework is well suited to accommodate individuals' values and beliefs in the policy process. The analysis of actors involves tracing the origins and development of the coalitions, each of which holds certain ideas, values and beliefs in common. The ACF challenges the mainstream idea of value-free science. It argues that agency officials and scientists are not "policy indifferent", but rather have "relatively complex belief systems incorporating multiple values and perceptions of problem severity, causes, and impacts" (Sabatier and Zafonte 1997, p.5).

The main focus of the coalitions framework is to explain policy change and policy learning over periods of a decade or more. Sabatier's framework is, therefore, less about policy implementation and more about policy change and decision-making. However, this thesis shows that the framework is useful for mapping out alliances among policy actors, which may enable or constrain policy implementation. Chapter Four analyses the main actors and their beliefs by following the ACF. In the following sections, I describe the relevant components of the framework: policy sub-systems, advocacy coalitions' resources, and policy participants' beliefs systems.

Policy sub-systems

Advocacy coalitions work within policy sub-systems or policy domains such as basic education, health care insurance, or urban development. The concept includes an issue-area or function that is the substantive dimension, plus a geographical dimension or territory where policies may be applied. In the cases studied within this thesis, the policy issue-areas are access to health care, and reproductive and sexual rights. The geographical area is Mexico City. Thus, these are the policy sub-systems that delimit the identified coalitions' scope of action. Policy sub-systems may also overlap and it is important to clearly identify where this occurs.

Advocacy coalitions

Policy-interested actors from different institutions or backgrounds, who share a common set of policy beliefs, may form advocacy coalitions. These actors include legislators, agency officials, interest group leaders, judges, researchers, journalists and specialists, and are motivated to translate their policy beliefs into actual policy. A key

feature of advocacy coalitions is to have “a degree of coordination” which involves “working together to achieve policy objectives” (Sabatier and Weible 2007, p.192-193).

The ACF highlights the role of researchers and specialists in the policy process. This is particularly interesting for this study since the coalitions I identify in the two policy sub-systems are based on research centres in the form of think-tanks, universities or NGOs. These institutions seek allies in other places, especially to actors with access to decision-making power or those holding government positions.

The degree of influence of an advocacy coalition on the policy process, including implementation, is measured in terms of its resources. Building on studies that use the ACF, Sabatier and Weible (2007) have developed a typology of policy-relevant resources that coalitions use to influence public policy. They identify six sources or types of coalition resources. See Table 2.1 below.

Table 2.1 Advocacy Coalitions Resources

Resource	Definition
Formal policy decision-making authority	Actors in formal positions of legal authority to make policy decisions, such as judges and legislators, are a major resource for coalitions. Dominant coalitions are those with more members in these positions than their opponents. Coalitions may have strategies to put more allies in powerful positions.
Public opinion	A favourable public opinion may result in the election of a coalition’s allies to strategic positions, thus advocacy coalitions seek to gain public support.
Information	A resource that serves to win debates with opponents; it is useful to have information about the policy problem, about alternatives, costs and benefits of proposed policies.
Mobilisable troops	They constitute an inexpensive resource to engage coalition members in activities such as public demonstrations, electoral campaigns and fund-raising.
Financial resources	Refers to money to pay for other resources like media campaigns, research, publications, etc.
Skilful leadership	Coalitions need leaders to attract and manage resources. A leader may also give cohesion to the coalition.

Source: Sabatier, P. A. and Weible, C. M. (2007). The Advocacy Coalition Framework. Theories of the Policy Process. P. A. Sabatier. Colorado, Westview Press: p.201

Policy participants and belief systems

The ACF bases its model of the individual on social psychology. It assumes that policy participants have stable beliefs that are somewhat difficult to change. These

normative beliefs act as *perceptual filters* in the way individuals relate to the world. This assumption is very significant because it diverges from the mainstream rational choice frameworks that define individual choice and actions in economic terms, that is self-interested and “rationally pursuing relatively simple material interests” (Sabatier and Weible 2007, pp.194-195). In fact, the different assumptions in the advocacy coalitions and rational-choice frameworks have been long debated by policy scholars. Is it material self-interest or policy beliefs that drive actors to behave and act the way they do? According to Sabatier and Weible, previous research indicates that “self-interest is more important for material groups (organizations motivated for economic self-interest) than purposive groups (organizations motivated by an ideological position)” (2007, p.197). Findings for both policies in the Mexican case support this argument, as explained in Chapters Five and Six.

Policy participants’ beliefs are important to examine because they explain policy conflict. The ACF points out that actors from different coalitions may perceive the same information in different ways, leading to distrust among coalitions. There is a tendency for actors to value losses more than gains, therefore seeing their opponents as more powerful and less trustworthy than them; this is what the framework has named the “devil shift”, which escalates and exacerbates policy conflict among competing coalitions (Sabatier and Weible 2007).

The belief system of policy participants is understood as comprising three levels in concentric circles. At the broadest level of the system are “deep core beliefs”, which are expressed in different policy areas and are not specific to a policy sub-system. These involve “general normative and ontological assumptions about human nature” and relative priorities of fundamental values such as freedom and equality, state and market, top-down and bottom-up, centralisation and decentralisation, obligation and entitlement, etc. The traditional left and right divide is placed at the deep core beliefs category. According to this framework, deep core beliefs are the product of childhood socialisation and are very difficult to change (p.194). At the second inner level are “policy core beliefs”, which are applications of deep core beliefs and are more specific to a policy area or sub-system. These beliefs deal with policy choices and are based on policy-related values like the relative authority of governments and markets, the causes of policy problems, whose welfare counts first. Policy core beliefs are also difficult to change because they deal with fundamental policy choices. They are salient and may be a major source of division

between coalitions, thus being the main factor holding a coalition together. Policy core beliefs are translated into “secondary beliefs” that are specific instruments or proposals about a policy problem within a territorial boundary. These beliefs are related to particular components of the policy sub-system, hence are narrow in scope, addressing issues in a more specific and detailed way. For example, rules and budgetary applications within a programme or project, participation guidelines for a particular statute, etc. (p.196). Secondary beliefs are easier to change than core beliefs; they are likely to comply with evidence and information about the policy problem.

One of the weaknesses of the ACF in this respect is that it places the most importance and level of influence on elite beliefs, disregarding those of lower level public administrators and street-level bureaucrats. It neglects the power of professionals as service providers, as well as the case of health care. The role of doctors and nurses in health provisioning is fundamental, and their power has been recognised by other scholars like Friedson (1970). The level of discretionality and decision-making over people’s health and life are just some of the sources of their power. Chapter Seven deals with the power of professionals in more depth, with an analysis of the role of civil society in policy implementation.

This thesis applies the ACF to the Mexican case in order to map out and profile key actors involved in the case studies. This analysis is presented in Chapter Four. The thesis combines the advocacy coalitions’ beliefs system model with the works of Vickers (1968) and Young (1979) who also address actors’ values and beliefs. The following section reviews the literature that addresses ideas, values and beliefs within policy studies. It explains how the thesis framework also builds on these.

2.3 Values and beliefs in the policy process

The underlying assumption of theories that consider values and beliefs as an important factor in policy processes is that people’s attitudes, opinions and actions are determined by their ideas, values and morals. These theories focus on what they understand as policy decision-making, that is agenda-setting and policy design, leaving policy implementation out. Vickers (1968), for example, argues that what matters is how individuals judge reality and make value judgements, because these judgements determine their actions.

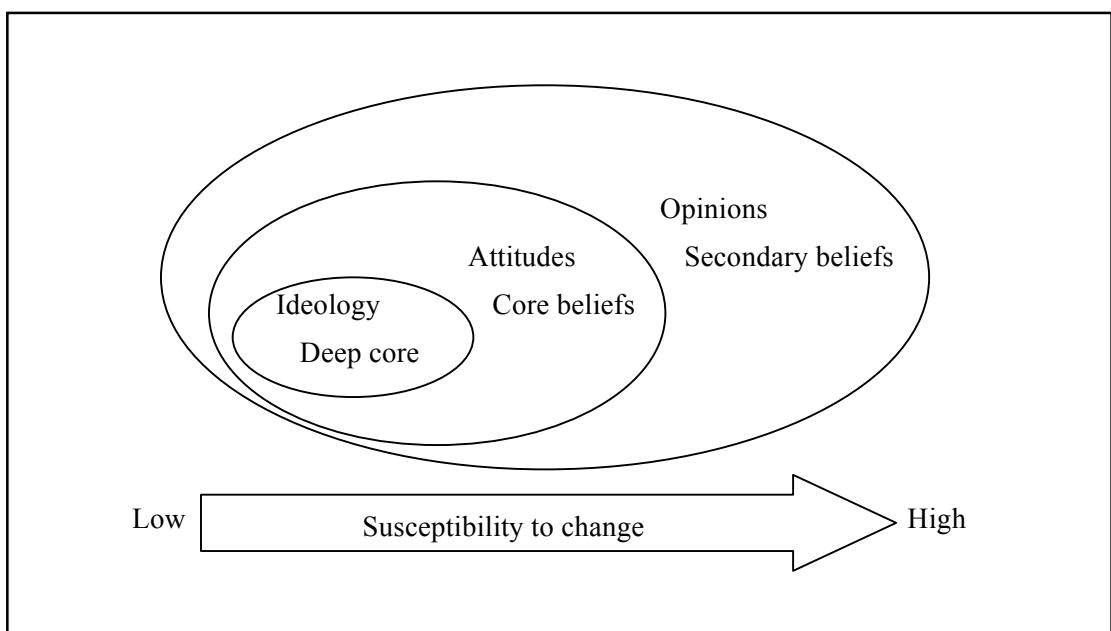
Policy actors' ideas and beliefs are factors that influence the implementation process at different levels. At the operationalisation level, ideas and beliefs of those individuals holding key positions in implementing agencies have an impact on the way policies are carried out. For this view, the works of Lasswell and Kaplan (1950) and Greenstein (1992) offer a suitable framework by which to explain the impact of individual actors on public policy. They argue that individuals matter in the policy process because political responses of individuals are determined by the environment/context as well as the individual's predispositions. It is in the concept of predispositions that these scholars place opinions, attitudes, beliefs, values, ideology, and stereotypes, among others like personality and temperament, and genetic inheritance (cited in Parsons 1995, p.370). In health policy, the ideas and beliefs of doctors, nurses and social workers as street-level staff, or face-to-face providers of public and private health services, are relevant since they may have a substantial degree of discretionality (Lipsky 1980).

To make sense and understand the ideas and values of policy actors, this thesis combines the advocacy coalitions' beliefs system and Young's organisation of the assumptive world. Young (1979) constructs a model of the "assumptive world" to explain how policy-makers understand policy problems and make decisions. He argues that the assumptive world is composed of cognitive and affective aspects; that is, beliefs and information as cognition, and values and norms as affect. It is through it that the transmission of culture occurs, hence the assumptive world is culture-specific. Young's assumptive world is organised in concentric circles that denote different depth levels (see Figure 2.1). At the centre is *ideology* as an immutable core; in the second outer level are *attitudes* which are adaptive; in the third and broadest level are *opinions*, which are changeable. Therefore, the closer a belief is to the core, the more difficult it is to change. Young defines ideology as the "most generalized symbolic representation of the world and our relation to it"; attitudes, as the mechanisms we use to "manage the concrete world presented to us"; and opinions, as the "circumstantially forged and specific representations of the world in its day-to-day encounters with us" (Young 1979, p.34).

Young's assumptive world model may be combined with the advocacy coalitions' beliefs system. The two frameworks assume different degrees, or intensity of beliefs, according to their susceptibility to change (see Figure 2.1). The ACF places secondary beliefs (information and policy instruments) at the outer level of the

system, meaning that they are easier to change or adapt. These correspond to Young's concept of opinions. Next are policy core beliefs (positions or strategies that lead to the desired results) that are comparable to attitudes in Young's model. At the centre are deep core beliefs (fundamental norms that can be applied to different policy subsystems) or ideology – as in the assumptive world model - which are the most difficult to change, or even immutable (Sabatier and Weible 2007; Young 1979).

Figure 2.1 Young's assumptive world and Sabatier's beliefs system



*Source: Adapted from Parsons, D. W. (1995), *Public policy: an introduction to the theory and practice of policy analysis*, (p.378).*

This combined framework is better explained through simple examples of different policies: gay marriage and productivity incentives for civil servants. For example, a person has the idea (deep core belief) that the ultimate purpose of sexuality is procreation. This idea determines this person's attitude (policy core belief) towards homosexuality, in that “it is against nature since gay couples are unable to procreate”. In turn, this attitude shapes the person's opinions about gay marriage and, most likely, also a discriminating behaviour towards gays. Young's organisation of the assumptive world is also useful to explain less controversial policies. For example, the policy problem identified is low productivity levels among civil servants in a certain government agency. Policy-makers may have different opinions (secondary beliefs) about how to deal with the problem. An option is to introduce a system of monetary incentives based on the amount of work produced by each individual. Policy-makers

in favour of this option give arguments to persuade others to change their opinions and have this policy approved. This opinion is based on the belief that individuals' behaviour is determined by material incentives (policy core beliefs). Therefore, by having the right incentives in place, people change their behaviour towards the desired outcome; in this case, higher levels of productivity. This belief is adaptive, corresponding to Young's concept of attitudes. It means that the policy-maker may adapt this belief to different circumstances. It is not easily changeable, but neither is it carved in stone. At the core is the ideology that holds those beliefs together; in this case, the basic idea is that human beings are material self-interested individuals (deep core beliefs). There are arguments in favour and against this idea, but it is more difficult to change or adapt. Ideas are the basis for beliefs that determine attitudes, which in turn give shape to different opinions.

The examples above illustrate how different ideas and beliefs can be the source of conflict in policy processes. Young explains conflict as a lack of homogenous culture. This framework becomes even more relevant in today's world, which is characterised by multicultural societies where public policies must cover different understandings of reality, different values and different beliefs. The study of ideas, values and beliefs in public policy processes become fundamental in understanding appropriateness and potential conflicts in multicultural societies.

Most of the literature concerned with policy conflict explains it as arising from tension between different values, preferences, and interests of policy actors. It also looks into how actors negotiate agreement. Susskind (2006), for example, differentiates conflicts based on interests from conflicts based on values:

Values involve strongly held personal beliefs, moral and ethical principles, basic legal rights, and more generally, idealized views of the world. While interests are about what we want, values are about what we care about and what we stand for. (Susskind 2006, p.272)

Susskind focuses on negotiation processes in defining policies and briefly mentions the potential problems that may arise during implementation. Susskind explains that, due to the changing of groups in the public sector over time, it is important to make their agreement "nearly self-enforcing". He suggests including incentives or penalties in terms of the agreement in order to avoid the "implementation problem". Although he acknowledges further conflict during implementation, this is not incorporated into

his analytical framework, but only suggests managerial mechanisms to deal with the problem.

Other policy analysis frameworks that focus on values and beliefs are those of Meier (1999), Haider-Markel (1999), Mooney (1999), Mooney and Lee (2000), and Stewart (2009). Aaron, Mann *et al.* (1994) argue that “values and norms condition the efficacy of public policy” (p.4). Some of these studies use the concept of “morality policies” to distinguish a type of policy, which is highly contested over moral or ethical grounds. They argue that morality policies cannot be analysed in the same way as other policies due to their particular characteristics. On the other hand, Stewart argues that all policies are intrinsically based on certain values, either explicitly or implicitly. These values, she argues, are “the informing principle of collective action”; they are related, but distinct, to political values like freedom, democracy, and equality (p.14).

Stewart (2009) presents an analytical tool to understand the values involved in public policies. She describes two functions of values: motivation and basis for choice. As motivators, policy values determine what is acceptable and what is not; they orientate political action and change. Stewart’s approach may be integrated into Young’s and Sabatier’s frameworks. Values as motivation may be understood as ideology or deep core beliefs since they may be explained as fundamental norms. Values, as a basis for choice, are compatible with secondary beliefs and opinions about means and ends. However, Stewart’s framework is not as developed as the other two. Nonetheless, the compatibility of these frameworks shows that there is a similar trend in understanding and analysing values and beliefs in the policy process. The analytical framework of this thesis is based on the ACF and Young’s organisation of the assumptive world. The analysis of ideas, values and beliefs of key actors is explained in Chapters Four and Five.

2.4 Service delivery literature

Policy implementation may be understood as public service provision if the observed policies are about the provision of public services, such as health and education. From this perspective, a trend in the literature is to look at “the problem of public service delivery”, that is, how to get good services for all. The World Development Report 2004 is dedicated to this issue and argues for stronger accountability mechanisms in

the service delivery chain. It describes two routes of accountability, the “long route” (citizens-politicians-providers) and the “short route” (citizens-providers). It argues that, by increasing citizens’ choice and participation, they are able to monitor service providers; plus, by increasing their voice through the ballot box, for example, they increase their influence on politicians/policy-makers. Some of the mechanisms the report suggests for achieving better service delivery are to separate policy-making from service delivery, contracting-out, regulation of private providers, performance controls and incentives, and competition in service provision (World Bank 2003). Le Grand (2007) describes the desired characteristics of public services as high quality services, managed efficiently, and delivered equitably. He argues that models of service delivery such as trust, voice, and command and control, have not given the right incentives to service providers. Instead, he suggests a choice and competition model, where user choice together with provider competition, may offer better incentives to providers in order to deliver high quality services efficiently, equitably and in a responsive way (p.38). The Mexican health sector is a good example of the different service delivery models. Given the plurality of the health system, different models work in parallel. For example, a social security system with a trust model is in place alongside a private sector that works with a choice and competition model. Yet, the system lacks a voice model for service delivery. The next chapter explains in more detail how the health system works in Mexico.

Different service delivery arrangements have been tried around the world. The World Development Report 2004, dedicated to public services provisioning, describes common modes of service delivery. Governments may contract services out to the private or non-profit sectors; this means that governments are still responsible for financing and provisioning, but services are delivered through nongovernmental providers. They may sell concessions to the private sector, which means that the private provider pays a sum of money to the government in order to provide the service. Decentralisation is another way to organise service delivery by transferring responsibility for financing and provisioning to lower levels of government, such as municipalities. Responsibility may also be transferred to communities, to citizens themselves, who are in charge of organising service provision. In some cases, direct central government provision is still used. In Mexico, the federal government still owns and manages general and specialised hospitals that provide services to the population without social security.

The public service delivery literature offers a framework to better understand models of service delivery and evaluate which ones may be more suitable under certain circumstances. It focuses on how to raise service standards and the efficiency of delivery systems. This literature points out relevant issues like citizens' participation and accountability, as well as private service delivery, decentralisation and other arrangements. However, it does not provide the necessary tools to analyse the interplay of political actors and how they can influence policy implementation. This thesis focuses on the translation of policies into actions, that is, on processes rather than on models, hence it builds primarily on other theoretical approaches. The goal is to understand how policies are being carried out and the factors that facilitate or constrain this process. To do this, the literature on the policy process offers a more suitable perspective and a set of analytical tools. Chapter Three explains the service delivery arrangements that are in place in Mexico City's health sector.

2.5 Managerial approaches

The emphasis on management skills in public administration emerged from the perceived inefficiency and weak capacity of governments to deliver services. Public choice theories argue that traditional public administration does not promote efficient performance and bureaucrats have no incentives to control costs (Batley and Larbi 2004, p.34). The move to the managerial approach, in particular the NPM, started during the 1980s in countries like the UK, New Zealand and Australia. The crisis of the welfare state and financial constraints led to a change in the way public administration was carried out. Public spending had to be cut and services had to become more efficient. Policy advisers found in economics and management sciences the tools to control spending and improve service delivery (Parsons 1995). Hughes (1994) describes the New Public Management as economics allied with modern management and applied to the public sector (cited in Parsons 1995, p.454). In the case of developing countries like Mexico, the managerial approach was introduced externally by multilateral and bilateral organisations which conditioned their support to the adoption of such tools (Larbi 1999; Tamez and Molina 2000a).

Reforms in the health sector of developing countries, in particular, have focused on 'getting the incentives right' and aim to use provider payments to optimise the utilisation of resources, transform clinical practice, and improve the quality of

care. Most of the time, these reforms have been advocated, supported and, in some cases, financed by international development organisations. Aid organisations like USAID have a clear NPM discourse. They favour free markets and ‘economic freedom’. USAID’s main recommendations for service delivery are the reduction of bureaucracy, streamlined management, increased cost-effectiveness, decentralised and ‘reorganised services’, and private sector involvement.

The main characteristic of this approach is the adoption of private sector business-type management practices and principles into public administration and services. The role of the state in the production of public services is questioned. NPM advocates for the reduction of the state to a steering or stewarding role rather than producing and delivering services. Decentralisation is necessary to increase efficiency and responsiveness since it brings the provider closer to the consumer. Market-driven mechanisms and competition, such as privatisation and contracting-out, encourage improvement of performance and better services to consumers (Hood 1995; Osborne and Gaebler 1992). NPM emphasises the use of incentives and controls in order to ensure effective implementation of policies and quality service delivery (McLaughlin et al. 2001). The World Bank also emphasises the importance of “performance incentives” for providers of services (World Bank 2003, p.18).

Control and coordination are very important for successful implementation under the NPM model. Corporate management planning is, therefore, used or applied to policy analysis or policy-making. The exercise requires a clear definition of goals and objectives; to understand present strengths, weaknesses, opportunities and threats; to identify strategies; creating an action plan, to then carry it out while having a monitoring system in place to correct any failure in order to reach established goals (M. Hill 2005; Parsons 1995). It provides rational tools such as cost-benefit analysis, systems analysis and programme budgeting (Minogue 1997).

Applied to policy implementation, the managerial approach suggests that effectiveness depends on good management of personnel, organisation, procedures and communications. Organisational and individual behaviour “is largely determined by controls and incentives which are specified through performance standards” (OECD 1987, cited in Parsons 1995, p.460). The underlying assumption here is that organisations and individuals are rational and apolitical, acting in a world where there is no conflict over values and beliefs. For this approach, human resources management means understanding how people respond to the tasks they are asked to

do and suggests two techniques to improve implementation: performance appraisal and management by objectives. In the UK, this model is known as “targets and performance management”. It works by setting numerical targets for public service providers to achieve and, based on results, rewards or penalties are imposed. Rewards may include financial bonuses or staff promotion; penalties can be greater intervention from outside the organisation or demotion of staff (Le Grand 2007). Like carrots and sticks, incentives help modify the behaviour of administrators and street-level implementers (Dunleavy and Hood 1994; M. Hill 2005; Parsons 1995).

Under the managerial approach, citizens relate to the state individually. The approach suggests a more direct link between citizens and government, avoiding civil society intermediation. In practice, this is translated as consumer surveys, consultations, or suggestion/complaint boxes or hotlines. What matters for the manager is how to know his/her clients and get the information needed from them in order to make better management decisions. Such “individual voice” mechanisms are favoured over collective mechanisms. Through individual voice, providers learn what is right and what is wrong with their services (Le Grand 2007). This is more helpful to providers than when consumers express their dissatisfaction through exiting (leaving a service provider and going to another that offers them better services) because managers can learn from it. Consumers may also rely on civil society intermediaries to articulate their concerns (Hirschman 1970). Choice mechanisms may be well suited in more pluralist sectors where there are a number of providers and the consumer does not incur extra costs to move from one provider to another. Chapter Six looks into these kinds of mechanisms to understand how managerial practices may help in improving performance.

In contrast to the NPM framework, policy approaches focus on structures, processes and relationships, power, interests and influence. These approaches are more interested in the means rather than the ends. They examine decision-making processes and how different circumstances affect those decisions. Historical and institutional contexts, as well as wealth and knowledge, are important factors that have an impact on policy processes. Most of the implementation analysis frameworks include political elements in their explanations, as described above. But the weight they give to them is what distinguishes political from managerial approaches. Chapter Six addresses how managerial practices may influence implementation in contrast to implementers’ ideas and beliefs.

Managerial approaches highlight the relationship with clients in an individual basis. As explained above, managers are interested in knowing their clients' preferences in order to attract more clients. However, they disregard collective voice and actions that other approaches suggest should be encouraged. The next section explains the underlying theory of this kind of approach.

2.6 Citizen participation and societal accountability

Different forms of citizen participation are suggested in the literature in order to improve public service delivery (Ackerman 2004; Blair 2000; IDB 2004; Mehrotra and Jarrett 2002; Murthy and Klugman 2004; World Bank 2003). This thesis builds on participatory democracy theory, also known as deepening democracy literature. It offers an analytical framework to understand the mechanisms and channels that citizens may use to have a say and influence policy. The wide acceptance of democracy as the most suitable political system in our times reflects the interest and advocacy for greater citizen involvement in policy-making. Fung, Wright *et al.* (2003) argue that real democracy means deeper and more effective participation by ordinary people to influence policies: "people should have a say in the decisions that affect their lives". Scholars like Beetham (1999) believe that the defining principle of democracy should be that "all citizens are entitled to a say in public affairs, both through the associations of civil society and through participation in government..." (cited in Gaventa 2006, p.12). Multilateral and donor organisations have taken this argument to define policies that encourage active citizenship and strengthen civil society. For example, a UNDP report published in 2004 calls for going beyond a "democracy of voters" to a "democracy of citizens" (UNDP 2004) by creating and supporting mechanisms to facilitate citizen engagement. The IDB published in 2004 its 'Strategy for promoting citizen participation in Bank activities' where it recognises the strength of democracy as based on "the active participation of individuals at all levels of civic life". The strategy refers to various regional agreements where delegates stress "the growing importance of citizen participation in public policy development and implementation" (IDB 2004). Governments have also taken up citizen participation. The emblematic example is Porto Alegre in Brazil with participatory budgeting. Every citizen can participate and vote on budget issues in regional and thematic assemblies (Avritzer 2006). The Porto Alegre experience and

similar policies have been replicated in other Brazilian cities, as well as in other countries. New Labour in the UK implements citizen participation and “community empowerment” policies such as the neighbourhood renewal programme and participatory budgeting. The programme aims to improve public services through community partnerships (Wallace 2001). The UK government aims to establish participatory budgeting in every local authority area by 2012.¹⁹

One approach to understanding how citizens engage in public affairs and policy is through looking at the relationship between citizens and the state. Democratisation processes, especially in Latin America, have shown the key role that CSOs play in bringing down dictatorships and oppressive regimes. Civil society provides a space where citizens share ideas and aggregate efforts to claim their rights. It is also an intermediary vehicle between the individual and the government. The term civil society is widely used and has different connotations according to who is using it and the purpose of using it. From academics to practitioners and politicians, the use of the concept of civil society has been absorbed into everyday language. The thesis uses a definition of civil society that is useful for framing the concept in the context of this study. “Civil society refers to the arena of uncoerced collective action around shared interests, purposes and values.”²⁰ Examples of CSOs are charities, NGOs, community groups, women's organisations, faith-based organisations, professional associations, trades unions, self-help groups, social movements, business associations, coalitions and advocacy groups.

The literature on democracy and citizenship focuses on voice rather than choice as a mechanism to express dissatisfaction with government performance (Hirschman 1970; Mehrotra 2006; Mintrom 2003; Paul 1992). It looks into the spaces where citizens may express their voice about the issues that affect their lives. Cornwall (2004) labels these as “new democratic spaces” and defines them as new arenas for public participation that seem to offer a place for citizen-state interactions. She argues that “thinking about participation as a spatial practice highlights the relations of power and constructions of citizenship that permeate any site for public engagement” (Cornwall 2004, p.1). This framework allows identifying diverse forms

¹⁹ Department of Communities and Local Government, March 2008, Participatory budgeting: a draft national strategy, <http://www.communities.gov.uk/documents/communities/pdf/727993.pdf> accessed 18/09/2010

²⁰ Centre for Civil Society at the LSE http://www.lse.ac.uk/collections/CCS/what_is_civil_society.htm accessed 15/07/2010

of citizen involvement in policy processes; whether they are created by initiative of governments or due to popular demand, or generated by citizens themselves in order to voice their claims. These paradigms emphasise the co-governance role of civil society to assure a fairer distribution of public resources. They also value the deliberation of new policies in citizen assemblies and see empowerment of the poor as a key tool to fight inequality. Most of these principles find their direct antecedent in the idea of ‘voice’ by Hirschman (1970).

Advocates for citizen participation have received criticisms about their view of participation. Cooke and Kothari (2001) challenge what they called “the participatory development orthodoxy”. They argue that “...participatory development’s tyrannical potential is systematic... the discourse itself, and not just practice, embodies the potential for unjustified exercise of power” (p.4). The concerns raised by these authors are significant and important. The relevance of this debate is to be aware of potential negative impacts of citizen participation and its mechanisms. However, the focus on this thesis is the extent to what regular citizens/service users may influence public policy.

The literature on citizen participation addresses a wide range of mechanisms for voicing demands and engaging in public affairs. For policy implementation specifically, it requires specific forms of participation. During this process, individual citizens or collectives may get involved by providing public services, by deliberating on resource allocation, as advisors for government agencies, or as accountability agents. This study looks at the accountability of public service providers, that is, the mechanisms through which service providers are held responsible for their performance. In order to better understand these mechanisms or activities, I refer to the concept of “societal accountability”, which emanates from studies in Latin America. Smulovitz and Peruzzotti (2000) define the term as “citizen action aimed at overseeing political authorities... a non-electoral, yet vertical mechanism of control that rests on the actions of a multiple array of citizen associations and movements and on the media, actions that aim at exposing governmental wrongdoing, bringing new issues onto the public agenda...” (pp.147, 150). Peruzzotti and colleagues argue that the traditional concept of accountability has largely ignored civil society; that, to be effective, societal accountability requires an organised society able to exert influence on the political system and on public bureaucracies (p.150).

The debate around accountability and its meaning is vast since there are different uses of the concept of accountability. Ebrahim and Weisband (2007) argue that the precision of the concept has become eroded given its extended analytical domains. They actually take a skeptical view, challenge dominant technocratic views and take an interpretative approach focusing on discursive meanings shaped by different realities and institutional settings. They suggest that accountability “is a means of social control used by the weak as well as the powerful”, and highlight social relations and configurations of power in addressing accountability analyses. In the same line of criticism of the concept of accountability, Jordan and Van Tuijl (2006) re-examine the boundaries of the concept and challenge more traditional definitions. These authors focus their work on NGO accountability, that is, the accountability that NGOs should have towards authorities and donors, as well as to beneficiaries and other stakeholders. From a different perspective, Bovens (2010) argues that the conceptual confusion of the term ‘accountability’ needs to be overcome in order to have a foundation for comparative and cumulative analysis. He identifies two main trends in the conceptualisation of the term: accountability as a virtue and accountability as a mechanism. As a virtue, accountability takes a normative stance: the standards for evaluating the behaviour of actors; as a mechanism, it takes a more descriptive stance: the institutional arrangements to hold an actor to account (p.946).

Following Bovens, this thesis focuses on accountability as a mechanism. Chapter Seven addresses the institutional arrangements that are available to citizens in Mexico City to hold service providers to account. These mechanisms provide the ways in which citizens may express dissatisfaction with the performance of public service providers and their responsiveness to such claims. I combine Bovens’ approach with Peruzzotti’s societal accountability approach.

The concept of societal accountability is useful for examining public service delivery. Peruzzotti and Smulovitz identify four main areas where societal accountability is most present in Latin America: citizen security, judicial autonomy and access to justice, electoral fraud, and government corruption. They stress the role of civil associations and nongovernmental organisations, like human rights commissions, civic networks that monitor elections, organisations that demand transparency and disclosure of public information, as well as the emergence of more inquisitive journalism (Smulovitz and Peruzzotti 2000). The authors believe that these

expressions “are crucial both at fostering more accountable democratic regimes and at expanding the scope of citizen’s rights” (p.209).

Building on the new democratic spaces and societal accountability frameworks, I analyse the ways in which citizens have engaged in the two case study policies in this thesis. This is useful in understanding how citizen participation may influence policy implementation processes in order to improve service providers’ performance. Chapter Seven looks into the participation of CSOs like NGOs, and spaces for citizen participation in issues related to the execution of public policies. The thesis looks at how medical associations have been involved or not in the policy process and how their (in)actions influence effective implementation. There are a number of different CSOs that are engaged in the implementation of health policies; for example, medical professional associations, civil servant unions, private health care providers associations, think-tanks and research institutions, each of which has a different agenda and interests. This study is concerned with *how* these organisations may influence the process of putting policies into practice.

Among the factors that may enable or constrain the effective implementation of policies is the participation of civil society. Citizens may engage in the process through different accountability mechanisms or democratic spaces. The function and effectiveness of these mechanisms and spaces in influencing policy implementation is the focus of Chapter Seven.

2.7 Conclusion

This chapter explained the theoretical framework that this thesis uses to address the research questions. The main concern is policy implementation and how different variables or factors may enable or constrain its effectiveness. The thesis proposes to look into the main policy actors and their ideas and beliefs, the ways that services are delivered to the population, managerial practices in place within implementing agencies, and citizen participation in the process and in holding service providers to account. Therefore, the theories that form the framework address these issues. The chapter started by reviewing theories of the public policy process and implementation studies. Policy implementation is defined, following a stagist approach, for analytical purposes. Implementation means translating policy into action and starts after a policy has been enacted. It does not include outcomes or policy results.

This thesis does not share the underlying assumption of policy approaches derived from rational choice theories. Those theories assume that self-interested individuals make rational choices to maximise utility. This assumption takes people's preferences for granted and disregards individuals' ideas, values and beliefs. Mainstream policy process theories share this fundamental premise. This thesis, instead, takes the assumption that individuals' preferences, attitudes and opinions are determined by ideas, values and beliefs. These are organised in belief systems according to their susceptibility to change. The ACF assumes a model of the individual based on belief systems; therefore, it seems an appropriate approach for the purposes of this thesis.

The ACF explains that actors form coalitions that aim to influence policy. There may be competing coalitions with conflicting ideas and beliefs that seek to achieve policy change in a given policy sub-system. Policy sub-systems are defined by an issue (health, education, urbanisation, and so on) and a geographical area. The power and influence of coalitions depends on the resources they have. Chapter Four analyses policy actors following this framework in order to understand how rival coalitions may constrain policy implementation. Although the ACF's main concern is policy change and policy learning over long periods of time, I find the framework very useful when explaining how policy beliefs influence implementation. Instead of dismissing policy implementation, proponents of this framework should recognise that it can also be applied to implementation, since coalitions are also involved in this process and may constrain or enable it in different ways.

The thesis also reviews the literature on ideas, values and beliefs within policy studies. In order to analyse these, I combine the advocacy coalitions' belief system with Young's organisation of the assumptive world. The key feature in both is the depth of ideas and beliefs because that determines their susceptibility to change. Implementation analysis is not only about coalitions but also about individuals. Young's framework is useful to look into the values and beliefs of individuals and it complements well with the ACF's framework. Effective policy implementation may require a change in beliefs of implementers. Chapter Six addresses the ideas and beliefs of implementers.

The two case study policies in this thesis entail the provision of health services. The literature on public services delivery is therefore relevant. This chapter reviewed this literature, highlighting the prominence of managerial practices and

citizen participation for holding providers into account. The most common service delivery arrangements were explained. This served as a framework for understanding how health care services are organised in Mexico City. Chapter Three gives an overview of the Mexican health system and a background of case study policies under study.

To look into managerial practices within implementing agencies, this chapter reviewed NPM theory. This literature suggests the adoption of private sector or business-type practices in public agencies in order to improve performance. It focuses on increasing choice and competition of service providers, target and performance management, as well as incentives and controls to elicit desired staff behaviour and raising efficiency.

The service delivery literature suggests the engagement of citizens in the decision-making and accountability of providers. This chapter built on/ drew on the participatory democracy theory to explain the rationale for increased citizen participation. Within this theory, the new democratic spaces and societal accountability approaches offer suitable frameworks to understand the mechanisms and channels by which citizens may get involved in policy implementation. Civil society's influence on the process is analysed in Chapter Seven.

3 Understanding the Mexican Health System

Health policy implementation cannot be understood without placing the process within the health system where it is carried out. The different actors and activities in a health system need to be analysed in order to grasp the development of health policies. This chapter provides a contextual background to understand the dynamics and relationships among actors in the Mexican health system. It explains the different service delivery arrangements that exist in the country, that is, how health care services reach the population. The chapter addresses the research questions on the way health policy services are actually provided to patients. It is important to know if health care services are decentralised, if there are contracts with private providers to deliver services, and so on. Effective policy implementation entails extending access to services, while the participation of private and non-profit sectors in delivering services also facilitates this. The health system's current features set the institutional and organisational environment in which health policies are executed. The chapter starts by discussing the definition of health systems and their functions. It then explains how the Mexican health system is organised.

The Mexican health system is comprised of different sub-systems. Public and private sectors are further divided: the public health sector includes social security and public health institutions, while the private sector may be divided into for-profit and non-profit sub-systems. Traditional medicine based upon indigenous peoples' knowledge of herbs is another way of providing health care, especially in remote rural areas. These sub-systems interact in different degrees and spaces, allowing – or not, as the case may be – for collaboration in achieving common goals. This chapter also explains formal spaces for interaction between health sub-systems in order to understand partnership opportunities for service delivery. The chapter ends by discussing recent reforms in health care in order to place the two policies that serve as case studies in a historical perspective.

The Mexican health system is complex. Existing literature on health systems does not offer a single appropriate framework by which to understand this complexity, as most of this literature focuses on developed countries. The best way to approach

the Mexican health system, and that of other developing countries, is to look at them as different sub-systems that coexist in the same territory and interact in different degrees. The following section explains this approach.

3.1 What is a health system?

The most accepted and widely used approach to define a health system is the one proposed by the WHO. A health system "...consists of all organisations, people and actions whose primary intent is to promote and maintain health" (WHO 2007, p.2). I use this definition because it is comprehensive and less restrictive than other definitions. The WHO actually has different definitions in different sources, but they do not contradict each other. The definition in its website,²¹ "A health system is the sum total of all the organisations, institutions and resources whose primary purpose is to improve health", does not include people and actions but only organisations and resources as components of a system. The different emphases of these definitions together offer a better perspective. A starting point in the study of health systems is to identify those organisations and institutions that devote themselves to the betterment of health. However, in order to fully understand how the system works, we need to consider the different actors and actions that these organisations carry out in order to achieve their goals. A health system's main purpose is to "promote and maintain health" – as the first definition states - and not only to "improve health", as in the second definition in this paragraph.

In a similar way, other definitions of a health system differ in their emphasis on certain elements or components, though they have the same basis. Roemer (1991) and Basch (1999) have come up with definitions of health systems in their efforts to map out and classify the diverse arrangements of health care provisioning around the world. Basch bases his definition on the provision of different types of health services and the resources allocated to them. The author classifies health care services as "promotive, preventive, curative or rehabilitative services", but leaves out of the definition the organisations or people involved, only referring to their actions as "organised arrangements". In contrast, Roemer takes a corporate approach and defines a health system as: "...the combination of resources, organization, financing, and

²¹ WHO website http://www.who.int/topics/health_systems/en/index.html accessed 02/12/2008

management that culminate in the delivery of health services to the population” (p.31). Notwithstanding the different emphases and specificities, definitions of health systems converge in the same basic components and purposes.

The main components of a health system, therefore, are as follows: *organisations*, which can be public, private, commercial, charities, local, international, and so on; *people*, such as the Minister of Health, a GP, a nurse, a patient, a student in medical school, and so on; *actions*, for example, certifying a hospital, paying health insurance, training new doctors, performing a surgery, providing vaccination; and *resources*, either human, financial or material that are used to achieve their goals. In order to understand how all of these interact and where they are situated within the health system, it is useful to identify their functions.

To look at service delivery arrangements, which comprise a central function of health systems, this chapter takes the framework proposed by WHO. The framework set out by WHO is widely accepted and used by both policy-makers and academics. It distinguishes four main functions of a health system: service delivery, resource generation, financing and stewardship. The *provision of health services* is perhaps the function that most people are familiar with. It refers to the point where patient and health professional meet: an appointment, a surgery, receiving vaccination, etc. The *resource regeneration* function refers to investing in human resources, physical capital and consumables. It is about providing the system with the necessary elements to operate. In order to do this, the system has to collect funds and purchase goods and services, that is *financing* the system. Finally, the fourth function of a health system is *stewardship*, which means the responsible management of the entire system. Most of this management is done through regulation and setting norms and rules (WHO 2000, pp.44-45).

Some definitions refer to *health care* systems rather than *health* systems. For the purposes of this thesis, there is no need to make this distinction; however, it is important to mention it. The definition of health care systems is more specific and refers to the provision of and investment in health services to individuals or the wider population (WHO 2000, p.6). Hence, health care is part of a health system but does not cover all of it. It does not include the generation of human resources and the stewardship functions of health systems. However, in some cases, both terms are used indistinctively. I use the term *health* systems in order to keep the more general

approach and the term *health care* when I focus on delivery of health services more specifically.

Although the focus of this thesis is on service delivery, it is important to be familiar with the system as a whole in order to see the conditions under which health policies are generated and implemented, and how the different actors involved in the system interact and relate to each other. This context sets the background for further analysis.

3.2 The Mexican health system

The Mexican health sector is far from being effective or efficient. It is way behind those of more developed countries. Mexico is a middle-income country with a GDP per capita of 14,201 USD in 2007 (PPP adjusted) compared to 35,601 USD for the UK. It has 105.6 million people, the third largest in the Americas.²² According to OECD data, Mexico spends a total of 5.7 per cent (2007) of its GDP on health, which is a low percentage compared with other countries. For example, Greece's health expenditure accounts for 9.6 per cent (2007), while for Brazil it is 7.5 per cent (2006). Contrary to the trend of most OECD countries, Mexico's public health expenditure is only 45 per cent of the total health expenditure, which means that the health sector is privately financed in more than half of the national total. Within the OECD, only in the US and Mexico does the percentage of total health expenditure by the private sector exceed that of the public sector – the OECD average of 73 per cent of total health expenditure is accounted for by the public health sector.²³

To situate the Mexican health system among other countries' systems, it is useful to use a common classification or framework to allow a degree of comparison. Most of the typologies of health systems are based on industrialised or developed countries, while very little has been done to provide a set of categories suitable for low- and middle-income countries such as Mexico (Mills and Ranson 2006). As Mills and Ranson 2006 explain, the various attempts to classify health systems are based according to different criteria, such as the method of financing, the underlying political philosophy, the extent of state intervention, the GNP level, and the historical

²² International Monetary Fund, World Economic Outlook Database, April 2009
<http://www.imf.org/external/pubs/ft/weo/2009/01/weodata/index.aspx> accessed 19/06/2009

²³ OECD Country Statistical Profiles 2009, <http://stats.oecd.org/Index.aspx?DataSetCode=CSP2009>
accessed 19/06/2009.

or cultural background (p.514). The OECD (1992), for example, classifies health systems according to their prime source of funding – voluntary or compulsory - and the nature of service provision – direct ownership of services, contracting-out, or private provision (cited in Mills and Ranson 2006, p.515).

Roemer's extensive work *National Health Systems of the World*, published in 1991, takes the economic level and market orientation of health sectors to classify countries. His work has been very influential. However, national health systems, especially in developing countries, are far more complex and do not easily or neatly fit into the author's various categories. Structural adjustment and other types of reform that have taken place during the past 20 years in the health sector make Roemer's classification out-dated. He has, for example, a category for "socialist and centrally planned" systems.

More recent attempts to classify or categorise health systems take state involvement in financing and delivery of health care as the determinant variables. State involvement seems to be a useful variable because it does not imply classifying national systems into different boxes, but rather implies a continuum with varying degrees. In this sense, Blank and Burau (2004) explain that, at one end of the continuum, there is a free market system while, at the other extreme, is government monopoly. The authors then describe three basic types of health systems: (i) the private insurance, or consumer sovereignty model, (ii) the social insurance, or Bismarck model, and (iii) the national health service, or Beveridge model. The private insurance model has the least state involvement and more market orientation in the funding and provision of services; the US and Australia are examples thereof. The Bismarck model is characterised by compulsory insurance, with universal coverage funded by employers' and workers' contributions and is often subsidised by the state. It tends to have public ownership of establishments but with private managing of service delivery. Germany and the Netherlands are examples of the Bismarck model. Finally, the national health service model, characterised by universal coverage funded by general taxation, is open to all citizens and is free at the point of use. Examples of this type of system are those of the UK and Sweden (p.24).

The task of classifying national health systems in low- and middle-income countries remains challenging. The main problem with existent classifications described before is that they all consider a single national health system, that is, as if there was only one main type of system in the country. In order to better understand

health systems in less developed countries, it is more useful to identify different types of systems in a single country, where one system may be more dominant than others but equally important. Taking the variable of state involvement, a number of different systems may well co-exist in one country. For example, there may be a publicly-owned health system serving a segment of the population while, at the same time, there is a private insurance system working in parallel. Therefore, it makes more sense to talk about different combinations of health systems, or sub-systems, since they are all ruled by the same Constitutional Laws.

The Mexican health sector can be better described as a set of parallel sub-systems with a varying degree of interaction among them. There is the social security sub-system, closer in its definition to the Bismarck model; the public health sub-system, which is similar to the Beveridge model; the private sector sub-system that follows a market orientation; the non-profit, following different market and non-market arrangements; and traditional medicine, which includes healers and herbalists. These sub-systems function in distinctive ways in terms of financing, service delivery and regulation (see Table 3.1). As each sub-system is in charge of its own functions, the Mexican health sector has often been described as a “vertically integrated and fragmented system” (Londoño and Frenk 1997; OECD 2005).

Table 3.1 The Mexican Health Sub-systems

Health systems →		Private sector	Social security			Public health		Non-profit	Traditional
FUNCTIONS	Regulation or stewardship (standardisation, quality control)	Commercial enterprises	IMSS	ISSSTE	Others (PEMEX, SEDENA and SEMAR)	Ministry of health and States health departments	IMSS-Opportunities	NGOs	Traditional medicine and home remedies
	Financing (insurance contributions or fee for service)								
	Service provision (health care delivery)								
Population served→		3%	40%	9%	3%	49%	Unknown	3%	
		Middle and upper class citizens	Formal sector workers Workers' families Retirees			Informal sector workers Self-employed Rural communities Urban poor	Middle class Working class Urban poor	Urban and rural poor Indigenous people	
Higher income					Lower income				

Note: Values do not necessarily add up to 100 as there is overlap between categories.

Source: Adapted by author from OECD (2005) Reviews of Health Systems: Mexico

Although each sub-system serves a share of the population according to socio-economic status, these divisions are not as clear in the real world. For example, people served by the public health sub-system may also use private and non-profit providers because there is a common perception that public health institutions provide low-quality services. According to the National Survey of Health and Nutrition 2006,²⁴ public health services have the lowest perceived quality of services. Usually, people using this sub-system do not have any other access to health care because they are not entitled to social security, or because they cannot afford it. However, it is interesting to note that an increasing share of private providers are targeting that population by

²⁴ Encuesta Nacional de Salud y Nutrición, ENSANut 2006, Instituto Nacional de Salud Pública

offering better quality services at very low prices, especially in urban settings.²⁵ I discuss health care providers in more detail later in the chapter.

Social security institutions

In Mexico, access to social security, including health care services, depends on the person's position in the labour market. Only workers in the formal economy, about 55 per cent of those aged 15 years old and older,²⁶ are entitled to social security, while everybody else is not. The latter, often referred to as the "uninsured population", account for roughly half of the total country's population (Frenk et al. 2006; OECD 2005) and include people working in the informal economy, self-employed professionals, people who work in family businesses, craftspeople, traders, small landowners and rural workers who are not organised into associations, and individuals who employ insured workers (Tamez and Molina 2000b). The "insured population" have access to a social security institution according to where they work. Therefore, workers in the private sector and their families are covered by the Mexican Social Security Institute or *Instituto Mexicano del Seguro Social* (IMSS), while federal civil servants are covered by the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE) or Social Services and Security Institute for State Workers. The army (SEDENA), the navy (SEMAR) and the state-owned oil company (PEMEX), have their own institutions that provide social security for its members and workers. These institutions work completely independently from each other but function in a very similar way. This distribution of social security is a result of the Mexican Revolution State which, in the 1940s and 1950s, laid down the arrangements and privileges for the most powerful sectors of the population supporting the state: the military, the civil service and working class.

In this sub-system, core functions are integrated in the same institution: each of them raises, pools and allocates funds to service providers that are also part of the institution. They have their own codes of practice, norms and regulations, which are consistent with the country's Constitution Laws. Health care professionals are employees of the institution and are paid on a salary basis.

The social security sub-system is the most advantaged in terms of public funding, creating a disproportional gap between these institutions and the Ministry of

²⁵ For example, *Farmacias Similares* and *Farmacias El Fénix*.

²⁶ World Bank data, <http://data.worldbank.org/country/mexico> accessed 09/09/2010

Health (SSA). The main funder of the sub-system is the federal government. The basic funding structure for each of the social security institutions is the same: a tripartite²⁷ contribution paid by the employer and the employee through pay-roll taxes, and a third contribution by the federal government coming from general taxation. Since the government is the employer of civil servants, the military and state-owned oil company, ISSSTE and the other institutions are funded by the federal government that covers both the employer and federal shares. Public funds that go only to the IMSS account for half of the total public health expenditure, while 8.7 per cent go to the ISSSTE and 35 per cent go to the public health system managed by the SSA. Public health expenditure per capita for the insured population is double the expenditure of those uninsured (Secretaría de Salud 2007).

The IMSS is the most powerful health care provider in the country and the largest in Latin America. This is reflected not only in the fact that it receives the greatest share of public health expenditure, but also because it provides benefits to that sector of society that has greatly supported the government: labour unions. The political weight of corporatist labour unions is represented in the National Congress, where a share of the seats is occupied by workers' leaders. The IMSS trade union is so powerful itself, with 360,000 employees in 2003 (Lloyd-Sherlock 2006), that it has been a major player in health sector reform. Several attempts at social security and health sector reform have been blocked by the IMSS trade union (Frenk et al. 2003; Tamez and Molina 2000a).

The range of health care services provided by these institutions varies according to their availability at specific hospitals or health centres. These can be outpatient care in hospitals or ambulatory clinics, hospitalisation, and specialised treatments, covering all three levels of attention. Medication is also provided if they are included in the established positive list. However, under-supply of medicines in health care units compels patients to buy their own medication privately; often, they also need to provide their own curative materials. These institutions do not have a defined list or package of services offered; instead, they only state the broad concept of providing health care to their beneficiaries.²⁸

²⁷ 33% of the IMSS budget is covered by the government, and 67% comes from employers and workers.

²⁸ IMSS, <http://www.imss.gob.mx/> accessed 14/07/2009; ISSSTE, <http://www.issste.gob.mx/> accessed 14/07/2009

The social security sub-system is the largest of all. These institutions account for almost half of the number of nurses in the country and 41 per cent of doctors (OECD 2005). However, these figures need to be considered in perspective, because a considerable number of doctors that work in social security institutions also work in the private sector. The extent of the phenomenon is hard to estimate because there are no data available; however, it is a well-known fact, which is also supported by fieldwork findings. In material resources, the sub-system has 38 per cent of the total number of acute care beds and 11 per cent of hospitals. Again, the IMSS accounts for most of the human and material resources of the social security institutions, laying claim to having more than 70 per cent of the system's doctors, nurses and beds (OECD 2005; Secretaría de Salud 2007).

Public health services

The public health services sub-system is managed and funded entirely by the SSA. The SSA was created in 1943 by merging two existing areas in the government – public health and public assistance – with the mandate to extend coverage to the poor and disadvantaged, and to be in charge of overall health policy and regulation (OECD 2005). Since then, the sub-system has been providing health care to the uninsured population,²⁹ namely those without access to the social security system. Although this proportion of the population encompasses a varied range of socio-economic backgrounds, the focus of the SSA has always been the poor (see Table 3.1). This sub-system was decentralised in two waves, one in the early 1980s in 14 of the 32 federal entities in Mexico, and the second wave in the mid-1990s covering the rest of the states. This means that each state bears responsibility for managing its own health care facilities. The SSA and state health departments are ruled by the Federal Constitution and the General Health Law.³⁰

As with the social security institutions, public health institutions have no pre-defined list of covered services. The sub-system offers services at the primary and secondary levels of attention at health centres and hospitals, and specialised treatments in some hospitals and institutes; most of them are concentrated in the country's capital Mexico City. Following decentralisation in the 1980s and 1990s, public health services have been run by the state health departments. However, the

²⁹ Also called “*poblacion abierta*”, open population.

³⁰ The last reform to the General Health Law was approved in Congress in 2004.

SSA still runs seven hospitals and eight national institutes located within Mexico City. These health units are directly managed and funded by the SSA; hence, they are federal units, which mean they are available to users coming from all states. The national institutes are third-level units specialised in different areas such as nutrition, children's health, oncology, neurology, and respiratory illnesses, among others. The institutes' main mandate is research and development, but they also provide highly-specialised treatments and hospitalisation.

The public health sub-system has to provide for a large proportion of the population using very limited resources, which often results in very poor quality of services (undersupply of medicines and curative materials, long waiting lists, rundown facilities, and so on). This sub-system, closer in nature to the Beveridge model, is funded by the federal government through general taxation; but state-level governments may also collect taxes to complement the federal funds. The level of state government funding varies considerably across states. For example, the Mexico City government provides 32 per cent of its total health care expenditure, while 68 per cent comes from the federal government. In Oaxaca, the state government only contributes 2 per cent, so most of the funding comes from the Mexican federal state. At the national level, only 35 per cent of total public health expenditure goes to the public health care sub-system. The per capita expenditure on health for the insured and uninsured populations is very disproportionate: \$293 USD and \$198 USD, respectively.³¹ Apart from the federal and state government funds, public health institutions charge a symbolic fee-for-service that users pay according to their income level. Funds from these fees only account for 1 per cent of the total public health sub-system budget (Secretaría de Salud 2007).

Available resources for the public health sub-system are very disproportionate compared to other sub-systems considering the size of its target population. Doctors working in public health units represent 32 per cent (2002) of the total doctors in the country. However, as I already mentioned, this figure needs to be treated with caution because many doctors in both social security and public health units also work in the private sector, and official data do not consider this double count. Health professionals are paid on a salary basis and not by services provided. The sub-system employs 34 per cent of the total number of nurses and has only 29 and 11 per cent of

³¹ Recursos Financieros 2008, SINAIS, http://www.sinais.salud.gob.mx/descargas/xls/frf_01.xls accessed 09/Sept/10.

available beds and hospitals, respectively (OECD 2005). About 54 per cent (2005) of public health hospitals have 30 beds or more, meaning that almost half of them are small hospitals with little capacity to accommodate patients. The distribution of resources is also disproportionate across states (hospital availability in terms of number of hospitals per 100,000 population); for example, in Baja California Sur it is six-fold, while in Campeche it is five-fold higher than that of Aguascalientes (Secretaría de Salud 2007). Hospitals are concentrated in urban areas, leaving the rural population with few options to access health care.

The disproportional distribution of health care resources is not determined by the relative wealth of states in terms of GDP per capita, nor by the amount of state funding spent on health care services. Further studies are needed to understand the differences among states and why these occur.

Private Sector

The private health care sub-system is the most heterogeneous within the Mexican health system. The nature of its components varies greatly. They range from individual doctors' practices to large health conglomerates offering high-tech treatments. Existing literature affirms that private services cater to the middle and upper classes (Funsalud 2001; Knaul et al. 2007; OECD 2004, 2005; Tamez and Molina 2000a). However, fieldwork findings suggest that the population this sub-system serves is also very heterogeneous. Any person willing to pay for private health care services may access them. An increasing number of private health providers are targeting the middle and lower classes, especially in urban areas, by offering cheaper and better quality services. The National Health Survey 2000³² shows that 39 per cent and 56 per cent of IMSS and ISSSTE enrollees, respectively, use ambulatory care from providers other than their social security institution. The percentages for hospital care are not small either: 28 per cent of IMSS enrollees and 46 per cent of ISSSTE's make use of other hospitals than those from their social security institution. According to the most recent Health Survey, in 2006, 37.6 per cent of the population used private health services.³³

³² Encuesta Nacional de Salud 2000, Instituto Nacional de Salud Pública.

³³ Use of health services during the 15 days prior to interview. ENSANut 2006. This survey did not follow up from the previous one (2000) about the use of services according to type of insurance.

Private health expenditure in Mexico for 2004 was 54 per cent³⁴ of the total health expenditure. Despite its relevance, very little is known about private health care in Mexico. This is a result of the lack of regulation that this sub-system has enjoyed over the past decades. Even today, there is no comprehensive information system on epidemiological data. I present here a sketch of the private health sub-system based on available secondary data, including primary information I collected during fieldwork.

At one end of the private health care spectrum are large conglomerates that own chains of hospitals nationwide. This type of provider offers all three levels of treatment in comfortable, state-of-the-art facilities. The largest of these companies is Grupo Ángeles, which owns 15 hospitals, 140 surgery rooms and 1,600 acute care beds, and employs 8,500 doctors in 40 different specialities.³⁵ Also parts of this company are smaller clinics located in residential areas that serve as a first point of contact offering primary care. Another of these conglomerates is StarMedica, which is currently owned by Carlos Slim, a telecom tycoon and the world's wealthiest person according to Forbes.³⁶ Grupo Ángeles and StarMedica are recognised as the two most powerful private health care providers in the country. StarMedica operates eight hospitals with 600 beds and represents 4,500 doctors.³⁷ Their growth rate is extraordinary: Grupo Ángeles is due to open twelve newly-built or acquired hospitals in the next couple of years, while StarMedica is opening three new hospitals. They are expanding even to attract foreign clients, especially from the US due to its geographical proximity to Mexico. Of the total admissions in 2007 by Grupo Ángeles Hospital in the border town of Tijuana, Americans accounted for 40 per cent of the total patients admitted. StarMedica signed an agreement in 2008 with a global health insurance company to provide services in its facilities to those taking out its insurance (Black 2008; Thomson Reuters 2008).

The way most of these types of health care providers operate is through private insurance companies and doctors, who refer their patients to them. It is common to have doctors' individual practices in the same location as hospitals. Doctors pay a

³⁴ Sistema de Cuentas en Salud a Nivel Federal y Estatal (SICUENTAS), <http://sinais.salud.gob.mx/recursosfinancieros/index.html> accessed 25/07/2009

³⁵ Grupo Ángeles, Servicios de Salud, <http://www.gass.com.mx/> accessed 29/07/2009

³⁶ http://www.forbes.com/lists/2010/10/billionaires-2010_The-Worlds-Billionaires_Rank.html accessed 14/09/2010.

³⁷ Portal StarMedica, <http://www.starmedica.com/default.asp>, accessed 29/07/2009

kind of rent to have their office there, and any use of hospital facilities and surgery rooms is charged to the patient in addition to the doctor's fee.

The private sub-system is very fragmented. At the other end of the spectrum are individual doctors' practices, or small clinics run by a small group of GPs or specialists that own the business. Small clinics, with just a small number of acute care beds, are the predominant type of private health provider. According to official data for 2005, 28 per cent of the total number of doctors work in the private sector together with 16 per cent of nurses. The sub-system accounts for 30 per cent of acute care beds and 75 per cent of the total number of hospitals in the country. However, out of this number, only 6.2 per cent are hospitals with more than 25 acute care beds and 69 per cent have less than 10 beds (Secretaría de Salud 2007).

The main source of health financing in Mexico is out-of-pocket payments that people without social security or private insurance have to make at the point of service delivery in order to cover the cost of health care. This kind of financing is recognised as the most inefficient and unfair available financing mechanisms (Sesma-Vázquez et al. 2005). Out-of-pocket expenditure in 2004 accounts for 95 per cent of the total private health expenditure, while payment for insurance premiums is only 5 per cent. Mexico has the highest out-of-pocket proportion of health financing in Latin America, accounting for more than half of the total health expenditure (Secretaría de Salud 2007). These figures reflect the high vulnerability that a large percentage of the population in the country has against catastrophic health expenditure.

Regulation is very poor in the private health system. By 2005, only 2.3 per cent of private hospitals were certified by the General Health Council (CSG) certification – the highest certifying authority in Mexico (Secretaría de Salud 2007). Most of the certified hospitals are large chain hospitals, as described above. The vast majority of private providers carry out their operations with no proper regulation. Prices and services offered vary across the sub-system and there is no regulation in this regard, either. Prices depend on facilities and types of service requested and are left to market forces.

The nature and characteristics of the private health sub-system reflect the inefficiency of public services, both social security and public health sub-systems, in providing adequate health care to the wider population. Private services are not only high-end hospital facilities, accessible only to the richer classes of society; private services are largely small-size clinics and practices used by the urban middle-low and

lower classes that the public health sector is supposed to serve. Since this type of health care provider is not properly regulated, users are left unprotected. They have to bear the cost of illness in full, paying out-of-pocket for services as well as medicines. In this sub-system, access to health care is not guaranteed, but instead depends on the user's capacity to pay.

Non-profit organisations

Very little research has been done on the non-profit health sub-system in Mexico. The number of establishments and resources used by these organisations are included in the private sector's figures. Available data on private health care is already poor, and this is even more the case with non-profit health care organisations. Nonetheless, the sub-system is visible and its importance cannot be ignored.

The non-profit and the for-profit components of the wider private health sector are distinctive in terms of financing, regulation and service delivery, which are the basic functions of health systems. It is important, therefore, to separate them in order to better understand their particularities and different roles in providing health care to the population. The main difference between these two sectors is in their nature: one aims to generate profits for share-holders, while the other does not. The non-profit health sector is characterised by a philanthropic spirit to assist the most vulnerable groups in society.

Legislation for non-profits and for-profits varies considerably. The non-profits are legally constituted as charities or civil associations. They benefit from tax exemptions and are able to exchange tax credits for donations received from companies and individuals. Unlike private companies, non-profits in general are also regulated by the Social Development Law and the Law for Social Assistance, executed by the Ministry of Social Development or *Secretaría de Desarrollo Social* (SEDESOL), and the National Social Assistance System or *Sistema para el Desarrollo Integral de la Familia* (DIF). The former is in charge of formulating, co-ordinating and carrying out the country's social policy, while the latter is in charge of regulating social assistance services, as well as establishing policies and guidelines for the development of assistance models in order to strengthen the professionalism of social assistance providers. These laws give priority to education and health among other social policies, such as risk and vulnerability, nutrition, income generation, and infrastructure (Diario Oficial de la Federación 2004a, 2004b). Non-profits providing

health care services are also under the General Health Law in the same way that other private health providers are. However, supervision, control and enforcement of these norms are very weak for the private and third sectors.

This thesis identifies two types of non-profit providers that are useful for the purpose of this study. The non-profit health sub-system can be categorised into two groups: issue-based and faith-based institutions. The first one refers to those institutions that specialise in one area of health, such as primary health, physical disabilities, mental health, blindness and poor sight, HIV/AIDS, reproductive health, and so on. The second group is characterised by their religious nature and comprises hospitals, small clinics and practices, and hospices mostly run by nuns or lay people with a strong commitment to their church. Some of these are located within parishes or convent facilities.

The most relevant difference in terms of funding between these two groups relates to the sources of funds. Faith-based health providers seem to be funded mainly by their church and by contributions from devotees. They also get in-kind and cash donations from private companies or individuals, from fund-raising events and lottery games. Funding sources for issue-based providers vary. They may include donations from companies and individuals, user fees or fund-raising events, but mostly rely on national and international foundations. Issue-based institutions are more likely to get public funds from the government because of their secular nature.

To illustrate the faith-based category, I use one of the most representative faith-based institutions that provide assistance, including health care, to the poor: Cáritas. This institution depends directly on the Catholic Church and it is run by both priests and lay people. It tends to use facilities within parishes to treat the ill and provide medicines as well. Funding comes primarily from the Church and devotees nationally and internationally. Its size and the services offered vary greatly from one place to another, in some cases having separate clinics with specialists, such as in Mexico City.³⁸

Issue-based organisations are more heterogeneous. At one end of the spectrum is Teletón, a large national NGO that offers rehabilitation services for disabled children. It has 13 state-of-the-art rehabilitation centres with the capacity to provide for 70,000 patients. This organisation is entirely funded by private companies and

³⁸ <http://www.caritas-mexico.org/> accessed 05/08/2009

individual donations.³⁹ Another typical example of this category is Mexfam, a national NGO working on reproductive and adolescent health. It is a member of the International Planned Parenthood Federation (IPPF) and has 24 clinics nationwide. About 20 per cent of its income comes from international sources, and the rest from national sources and user fees. It provides specialised services in reproductive and sexual health at low prices.⁴⁰

The non-profit health services are an option for those who are either excluded from other sub-systems or are not satisfied with their services. The non-profit, as well as the private, sub-system allows people to “exit” other providers if the service needed is on offer by non-profits. Its existence may benefit the health system as a whole. Again, more information and further studies are necessary in order to gain a better understanding of this relatively small, but important, health sub-system. This thesis shows the relevance of the non-profit health sector in expanding access to services and contributing or obstructing the implementation of health policies.

Traditional medicine

Traditional medicine in Mexico dates back to Pre-Hispanic times and it is still practised by indigenous peoples. The indigenous population in the country is approximately 6 per cent of the total population according to the 2010 census (INEGI 2012). This segment of the population is the most poor and marginalised, having the least access to public health care or allopathic medicine. They have kept their traditions and ancient knowledge in the use of plants and herbs to cure not only the body but the ‘spirit’ as well (Zolla 2005). These practices have been increasingly recognised by the wider Mexican society; some universities offer formal courses on traditional medicine.⁴¹ However, traditional healers and herbalists are not certified or recognised by state health authorities. During the 1970s, the government launched a programme to extend health care coverage, especially to rural areas where indigenous populations are located. This expansion of services did replace traditional healers and herbalists, but people still rely on traditional knowledge on health in remote areas. Healers are often paid with a voluntary cash or in-kind contribution by the patient.

³⁹ <http://www.teleton.org/> accessed 05/08/2009

⁴⁰ Interview with Vicente Díaz, Mexfam Executive Director, 16/05/2008

⁴¹ Universidad Autónoma del Estado de Morelos, Universidad Autónoma de Chapingo.

The sub-systems in the Mexican health sector illustrate the complexity of health systems in developing countries. Different types of institutions provide health care, some more effectively than others. This fragmentation of the system constrains collaboration between two or more sub-systems. There are no concerted efforts to improve performance and this increases inequality in both access and quality of services. The growth of the private health sub-system, especially the sector serving the lower urban classes, is a sign of the inefficiency of public sector services. In the end, people have to pay for health care when in need, making access to health care services dependent on the purchasing power of the consumer.

Mexico's health system needs to work in closer coordination and collaboration to achieve the MDGs on health. The public sector alone does not have the required resources to face public health challenges. The following section explains the formal channels in which the health sub-systems interact with each other.

3.3 Health System interactions

Regulation or stewardship, resource generation, financing and service delivery are the health systems' main functions. Mexican health sub-systems interact in spaces or intersections for different purposes. These intersections offer opportunities for sub-systems to arrange partnerships or collaborations to carry out some of the health system's functions. The two main functions where the sub-systems come together are regulation and service delivery.

Regulatory bodies

The General Health Council (CSG) is the highest health sector authority in the country. It is in charge of making decisions on sanitation, providing insights on health legislation and policy, coming up with recommendations for human resources formation, as well as advising the Presidency in all matters regarding public health and sanitation. Representatives of three health sub-systems – social security institutions, public health services and private sector - have a seat with voice and voting power in the council. The cabinet of the CSG, as determined in the Council's internal regulation, is made up of the Minister of Health acting as president of the council, directors of social security and public health institutions, educational

institutions directors, presidents of medical professional associations, and research institutions directors (Diario Oficial de la Federación 2002).

From the year 2000, it has been the responsibility of the CSG to write and keep up to date the catalogue of basic medications and consumables for the health sector, and to certify health care institutions according to established standards.⁴² Two commissions within the Council are in charge of each task. Representatives of the public health care institutions integrate the catalogue commission, that is SSA, IMSS, ISSSTE, SEDENA, DIF. Only public institutions play a role in this area because the catalogue is only adopted by public health care providers, while private providers are not required to adhere to it. In contrast, the certification commission is integrated by educational institutions and associations, medical professional associations, and private health care providers associations.⁴³

Health and sanitation controls are the responsibility of the SSA through the Federal Commission for Protection against Sanitary Risks (COFEPRIS). This commission is only made up of civil servants but has a mandate over both public and private sectors, especially in health care delivery establishments and pharmaceuticals.⁴⁴ COFEPRIS is in charge of the quality control of medicines produced and sold in the country, hence its interaction with pharmaceuticals.

The Council's composition is interesting and raises questions about the legitimacy of sector representatives. The internal regulation establishes which particular institutions may have a seat in it, but it does not explain the criteria for choosing them. Unfortunately, there are no studies available about the influence of council members on decision-making. However, its apparent plurality is a good sign in terms of bringing different perspectives and positions to the table of such an influential regulatory body. Chapter Seven looks in more depth into the civil society component of the Council, with a focus on citizen participation spaces.

Service delivery

There are some examples where social security and public health sub-systems have collaborated in providing health care to the uninsured population. The IMSS, as the most powerful and resourceful of the sub-systems, agreed to operate a Ministry of

⁴² <http://www.csg.salud.gob.mx> accessed 01/09/2009.

⁴³ The National Association of Private Hospitals

⁴⁴ <http://www.cofepris.gob.mx/> accessed 01/09/2009.

Health programme to extend health care coverage to the rural population lacking access to health services. From the 1980s, the programme *IMSS-Solidaridad* set up health centres in marginalised areas, especially rural, to attend these communities. Facilities are owned and operated by IMSS but financed by the Health Ministry. By December 2008, the programme – now called *IMSS-Oportunidades* for political reasons⁴⁵ – operated 3,617 primary care centres and 69 second level facilities⁴⁶ nationwide.

In order to expand access to services by the uninsured population, the IMSS agreed to open its health centres and hospitals to this section of the population in 1997. Through the Insurance for the Family programme (*Seguro para la Familia*), a voluntary insurance scheme, people outside the social security sub-system can purchase insurance with a premium that covers both employer and user contributions, but still benefit from the federal contribution, which accounts to 13.9 per cent of the total cost. However, this insurance scheme has not attracted the intended sector of the population because of its high costs and requirements, as well as the lack of publicity concerning this option (Tamez and Molina 2000a).

Regarding private and non-profit health care providers, a 2003 reform in the health sector allows for their participation in a publicly-funded insurance scheme. The PHI, which is one of the two health policies under analysis in this study, has a demand-driven logic. Federal funds are allocated according to services provided to insurance holders, instead of allocating them directly to providers regardless of the number of insurance holders treated (supply-driven). Private health care institutions are allowed to participate in the programme, therefore offering services to PHI holders and being paid for that by the government. Nonetheless, private sector participation is very small across the country. The PHI scheme is explained in more detail later in this chapter.

The existing mechanisms or spaces for interaction among different health sub-systems are very limited. This does not encourage but rather hinders possible collaboration between different sub-systems. The lack of spaces for collaboration in the Mexican health sector is a feature that may constrain the participation of private and non-profit sectors in health policy implementation.

⁴⁵ The flagship social development strategy of the party in government until 2000 was called “Progresista”, when a different party entered the government, the name was changed to “Oportunidades”.

⁴⁶ <http://www.imss.gob.mx/programas/oportunidades/> accessed 01/09/2009

The following section reviews health sector reforms taking place in the last three decades. Observing these reform processes is useful in order to see the relevance of the chosen policies as case studies. Both the PHI and the ILE are two of the most groundbreaking policies of recent years. Their enactment is very significant, since other health policies have failed to be approved or have only been partially accepted.

3.4 Health sector reforms

Different reforms within the health sector have shaped today's health sub-systems. From the 1980s, three different sets of reforms have dominated the health sector. These comprise the structural adjustment reforms recommended by the World Bank after major economic crises, the introduction of market mechanisms during the 1990s, and then the most recent reform in the early 2000s with the System for Social Protection in Health.

The early 1980s reforms: structural adjustment

The set of health reforms carried out in the 1980s were part of a wider national structural adjustment to overcome the economic crisis that Mexico was going through. Interestingly, the first step in these health sector reforms was the inclusion of the "right to the protection of health" in Article 4 of the National Constitution in 1983.

Health sector reforms intended to create a national health system through mechanisms like decentralisation, administrative modernisation, coordination between the different sectors, and community participation. There was an explicit adoption of the primary health care paradigm⁴⁷ and several efforts to extend health coverage by strengthening the public supply of health services and through decentralisation of facilities (Frenk et al. 2003). However, these goals were not met and even decentralisation, which was the priority, was only accomplished in 14 of the 32 states of the federation. The reforms implied a change in the balance of power between different institutions, putting the Ministry of Health at the top. Therefore the IMSS, which saw its exclusive access to resources threatened, led an opposition movement that also included labour organisations (González et al. 1995 cited in Tamez and Molina 2000a).

⁴⁷ Mexico subscribed to the Alma-Ata Declaration.

During the next presidential administration (1988-1994), most of the reforms previously undertaken were put on hold. The decentralisation process did not continue and, in its place, selective programmes were introduced targeting the poorest population groups. Under pressure to sign the North American Free Trade Agreement (NAFTA), regulations were modified to allow international companies to participate in private health insurance, resulting in an increase in pre-paid medical insurance. Other programmes to extend health care coverage were introduced with support from the World Bank. The Programme to Support Health Care Services to the Uninsured Population (PASSPA) was designed to improve infrastructure and access to services in four of the poorer states in Mexico. Then came the Programme for Extending Coverage (PAC) in 1995, which introduced a basic package of interventions (Tamez and Molina 2000b).

The mid-1990s reforms: decentralisation and marketisation

During this period of reforms, the decentralisation of the public health sub-system was resumed and by 1997, all 32 states, including Mexico City, had signed the agreement. This resulted in the total transfer of property and materials from the SSA to the states' newly-created health departments and the passing on of earmarked budgetary resources. Each of these state departments is in charge of providing health services in their states, which include medical attention, epidemiological defence, prevention and control of diseases. They are also responsible for the administration of financial, human, and material resources.

The social security sub-system also underwent a set of reforms. Financing sources were restructured, augmenting the proportional contribution from the federal government from 4 per cent to 33 per cent of IMSS's budget. Market mechanisms were put in place for the administration of pension funds. Collective funds were replaced by individual ones and the worker could now choose the financial institution to administer his/her fund. With this reform, IMSS and ISSSTE now compete with private institutions to manage pension funds. Throughout the entire process of reform, *IMSS-Oportunidades* (then *IMSS-Solidaridad*) was not modified. IMSS continues to provide services in marginalised rural areas in coordination with the Ministry of Health and state health departments. The services provided through *IMSS-Oportunidades* are part of a poverty alleviation programme that conditions cash transfers to school attendance and periodical health checks.

Similar to the reforms of the 1980s, other initiatives to reform the social security institutions failed. The separation of financing and provisioning functions of health care, allowing IMSS to contract services out, were not approved. Neither were other initiatives approved, such as allowing workers to choose their doctor at the primary level, or allowing employers to opt out of IMSS and provide private health insurance to their workers (Gómez-Dantés et al. 2004). These reforms failed to be approved mainly because of pressure and opposition from the IMSS's labour union (Lloyd-Sherlock 2006).

The early 2000s reforms: Social Protection in Health

The most recent health sector reform was approved in April 2003 by the national legislature. This reform aims to provide universal health care through the establishment of a Social Protection in Health System (SPSS), which covers those people, most of them poor, excluded from the social security sub-system. An original feature of this new policy is that it explicitly separates financing for “personal” and “non-personal” health services. A specific fund for non-personal health services was created in order to ensure financing for health-related public goods, such as environmental services, epidemiological surveillance, information, research and stewardship functions, and for community-based campaigns to promote preventive health actions (Frenk et al. 2003). With regard to personal health services, the SPSS established the Popular Health Insurance programme. This insurance scheme is funded through a tripartite formula with tax-based contributions from the federal and state governments and family contributions in accordance with their capacity to pay.

The reform aimed to financially restructure the Mexican health sector based on three public health care schemes: the IMSS, protecting formal sector workers; the ISSSTE, covering state employees; and the SPSS, bringing access to those outside the formal economy and to their families. All three insurance schemes have a tripartite financing structure: a uniform federal government contribution, employer, and user contributions. In the case of the PHI, the employer contribution is covered by state governments. I explain this policy in more detail in the following section.

3.5 Health policies under study

This overview of the Mexican health system and its reforms provides a backdrop to contextualising the two policies observed in this thesis. This section introduces the two policies, generally known as the “Popular Health Insurance” and the “legal termination of pregnancy”, or ILE, their aims and background. This is useful to better understand their intent and content, thus enabling the analysis of the implementation process described in the following chapters.

The two policies are significant for the Mexican health system as well as for the population. The PHI scheme is the most important health reform so far of the 2000s. It is particularly interesting because, for the first time, private health care providers are able to participate in the delivery of public health policies. The ILE, approved in Mexico City, is a ground-breaking policy, not only in Mexico but throughout the whole of Latin America. Sexual and reproductive health has been on the global agenda for several years, yet, in most Latin American countries, voluntary abortion is a crime. It is very interesting to observe and document how these policies are actually translated into day-to-day practice because of their relevance in the Mexican context. They have important implications for other countries following similar reforms.

Popular Health Insurance

The Popular Health Insurance is the health care insurance component of a package of reforms called System for Social Protection in Health (SPSS). As explained before, the SPSS was envisaged as the third “pillar” of the national health system by providing access to health care services to the uninsured population. Therefore, the national health system would achieve universal access through the PHI scheme, the IMSS and the ISSSTE - the other two “pillars” of the system (Secretaría de Salud 2006). The reformed General Law in Health, published in May 2003, defines the SPSS as a mechanism through which the state guarantees effective, timely and quality access to health services without payment at the point of service. It encompasses actions like health promotion, prevention, diagnosis, treatment and rehabilitation, including medication.

The SPSS differentiates personal from community health services. The first refers to curative services for individuals, as opposed to the second type of services

that are directed at a whole community and are primarily preventive, such as general sanitation. Community services also include information campaigns to promote healthy living styles. Personal health services, through the PHI, cover an essential package of services and a package of high-cost treatments. Both packages are selected according to priority, taking into account the epidemiological profile of the country and cost-effectiveness of interventions. The law establishes that, as a minimum, essential services must include primary level treatment, as well as outpatient care and hospitalisation in areas such as internal medicine, general surgery, gynaecology and obstetrics, paediatrics and gerontology. To finance high-cost treatments, the SPSS provides a separate fund in order to protect families from incurring catastrophic health spending.⁴⁸ The Fund for Protection against Catastrophic Expenditures (FPGC) covers costly treatment of diseases like HIV/AIDS, cervical and breast cancer, leukaemia, cataracts, among others.

The reform, enacted in May 2003, was put into practice from 1 January 2004. It allowed for the creation of an organisational structure to operate the new system. At the top is the Ministry of Health, which is in charge of coordinating, regulating and supervising the SPSS; to this end, the National Commission for Social Protection in Health (CNPSS) was created. Some of the Commission's tasks are to manage the provision of third-level treatment in federal health care institutions, to transfer federal contributions to the states, to design the tools and schemes of family contributions, to define providers' accreditation and certification standards, as well as to define the organisational framework and evaluate performance of all administrative levels in the system. The Commissioner is appointed by the President of Mexico from three candidates suggested by the Minister of Health and the SPSS National Council. This council, with advisory competence only, is made up of the Minister of Health, the Ministers of Social Development and Finance, as well as the IMSS and ISSSTE directors. The General Health Council also sits in the SPSS Council, together with five rotational seats assigned to states' departments of health (Diario Oficial de la Federación 2004c).

The SPSS operates through the Ministry of Health and state departments of health. The law establishes the creation of state-level units to operate the PHI. These

⁴⁸ Catastrophic health expenditure is defined as health expenses that push a household income below a poverty line. It is measured as a proportion of a household's income net of food spending. In Julio Frenk et al., 'Comprehensive Reform to Improve Health System Performance in Mexico', *The Lancet*, 368/9546 (28 October 2006 2006), 1524-34.

units are supposed to work independently but in coordination with the corresponding state health department. State SPSS units are in charge of enrolling people in the PHI scheme, providing health care services to beneficiaries, managing federal contributions, collecting and managing families' fees, and of ensuring and assessing the programme's implementation (Diario Oficial de la Federación 2004c).

Financing comes from three sources: the federal government, state governments and beneficiary families. The federal and state contributions are based on the number of families enrolled, potential enrollees, enrolment targets and health care provision capacity. The federation pays 15 per cent of the minimum wage (\approx £130 annually) per family, while the states are to cover at least half of this amount. Financial resources are allocated to and administered in three earmarked funds – community health services, personal health services, and catastrophic health expenditure. The fee that each family has to pay is determined according to capacity to pay through a standard socioeconomic assessment that distributes families in income deciles. The two lowest income deciles are exempt of this payment, but from the third to the highest income decile it is compulsory if they wish to join the SP. For 2008, the lowest income decile was set at roughly £315, the second lowest to £540, and the third to £740 (annual income). The highest income decile was set at £6,850 for the same year.⁴⁹ The annual family fee for the highest income decile is approximately £500, and £32 for the third decile.⁵⁰

Health care delivery is the responsibility of each state government through the decentralised public health care facilities. State governments are allowed to establish inter-institutional agreements with other state governments, social security institutions and private health care institutions, in order to be able to satisfy demand for services. Fees and compensation for services provided are negotiated and settled in agreements set by the parties involved.

Quality and standardisation of health care is important; therefore, service providers must be accredited or certified in order to be able to participate in the programme. Standards are set and verified by the SPSS Commission. Some of the

⁴⁹ INEGI, Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH) 2008, at <http://www.inegi.org.mx/inegi/contenidos/espanol/prensa/comunicados/enigh2008.asp>, accessed 13/06/2011

⁵⁰ http://www.seguro-popular.gob.mx/images/contenidos/Afiliacion/CuotasFamiliares/Cuotas_Familiares_Seguro_Popular.pdf accessed 04/09/2009

items they observe include the professional credentials of staff and medical personnel, the range of services offered, the appropriateness of facilities, and so on. By the end of 2008, only 49 per cent of public health care units were accredited (Comisión Nacional de Protección Social en Salud 2009).

The way the PHI works is that families are assigned to a primary-level health centre according to the place they live. If there is more than one option, the family is able to choose the centre of their preference. Health centres are the gatekeepers of the system and only through them can patients be referred to hospitals for secondary and third-level attention, with the exception of emergencies where patients can go directly to hospital.

Four years after its inception, the PHI had enrolled 27.2 million people, equivalent to roughly 25 per cent of Mexico's total population. However, this number does not necessarily mean that access to services has increased. The total number of interventions and services provided has not increased considerably. The availability of facilities and services has grown very slowly. Of the total number of enrollees, only 4 per cent pay an annual family contribution and for the rest it is free, thus posing a serious threat to the SPSS's sustainability. The largest contribution to the budget comes from the federal government, which is vulnerable to financial and economic crises and restrictions on public spending. In 2008, the federal contribution to the total SPSS budget was 68 per cent, the state governments put in 31.4 per cent and families' fees accounted for 0.6 per cent (Comisión Nacional de Protección Social en Salud 2009).

Legal Termination of Pregnancy

Mexico City is the first federal state to legislate in favour of voluntary abortion in Mexico, and one of the few places in Latin America to completely decriminalise it. The reform of the Criminal Code was enacted in April 2007 by a left-dominated local legislature. Already in May the same year, the first procedures under the new law were carried out. The reform decriminalises voluntary or induced abortion during the first trimester of pregnancy, and guarantees access to the service through the local public health care sub-system. This move has been most controversial in Mexico, the second largest Roman Catholic country in the world.

Unsafe abortion is recognised as a public health problem by health authorities in the country. It is the third most important cause of maternal mortality⁵¹ and yet access to safe abortion for most women in Mexico is highly restricted.⁵² Due to its criminal status, accurate numbers of induced abortions do not exist and estimates can only be calculated using the number of women treated in public hospitals for induced abortion complications. Juárez, Singh *et al.* (2008) estimate a total number of induced abortions in the country at 875,000 – an equivalent of 33 per 1,000 women. In the year 1990, this rate increased 33 per cent from 25 per 1,000 women. For Mexico City, the estimate is 165,000 induced abortions, representing 19 per cent of the country's total pregnancy terminations.

The abortion reform in Mexico City in 2007 was ground-breaking, but smaller policy changes preceded it. The first of these changes came in the year 2000 with the Robles Law, named after Mexico City's (woman) governor who pushed the reform. During that time, the City followed the Federal Criminal Code, unchanged since 1931 on matters regarding abortion. This Code, still the applicable statute under federal jurisdiction, defines abortion as a criminal act. The punishment is severe – 1-5 years imprisonment for women having an abortion, and 1-8 years for those performing the abortion. It also established reduced sentences for women without a “bad reputation”, “that have been able to hide their pregnancy”, or for whom “the pregnancy is the result of an illegitimate relation”. All three conditions must be met for sentences between six months to one year. The Code allows for cases where the crime “is not punishable”; for example, when it is caused by the “mother’s imprudence” (that is accidents), in case of rape, or when either the woman or “the product” are at risk of death (Diario Oficial de la Federación 1931 art.329-34). The language of the Code clearly shows the out-dated and moralistic nature of these norms.

The Robles Law changed the Federal Criminal Code for local legislation in three key areas: (i) the differentiation of punishments between women with ‘good’ and ‘bad’ reputations was eliminated; (ii) the crime of abortion was only punishable if it was successfully carried out, eliminating intent from the crime; and (iii) the causes for sanctions not to be applied were increased. The latter was the most important policy change because it allowed women to access safe abortion in cases not allowed

⁵¹ Sistema Nacional de Información en Salud, base de datos de defunciones 2007
<http://www.sinais.salud.gob.mx/muertesmaternas/index.html> accessed 18/01/2011

⁵² Most states in Mexico do not punish abortion only in cases of rape, accident, or risk of woman or foetus death.

in most of the other states in the country. The cases added to the list of non-punishable crime included: when the woman was inseminated without her consent; when there is a threat to the woman's health; when there are genetic and congenital conditions affecting the foetus "which may result in physical or mental damage" (Gaceta Oficial del Distrito Federal 2000). The switch in the language from "mother" to "woman" and the focus from social morality to woman's wellbeing were the most important issues that the *Ley Robles* addresses in order to achieve the 2007 reform.

In 2002, the local congress published the New Criminal Code for the Federal District to which the Robles Law was added after revisions. The revised law was enacted in 2004. The New Code made a very significant and yet unnoticed change in the Robles Law: instead of exempting punishment for certain cases, it effectively decriminalised, for the first time, abortion in those cases by stating that those conditions (rape, congenital malformation of foetus, risk to woman's health, and artificial insemination without consent) were "considered reasons to exclude criminal responsibility" (Gaceta Oficial del Distrito Federal 2004 art.148). Contrary to the original Robles Law, this policy change was not challenged in the Supreme Court by conservative groups; hence, it passed without much public debate and media attention.

Another important change in the 2004 reform was that it included a clause allowing "conscientious objection" on the part of medical practitioners. But in those cases where an objection was made, the health care provider had the obligation to refer the patient to another non-objecting practitioner. The implications of this clause for the later reform proved to be very significant, as later chapters explain.

The biggest change in sexual and reproductive health policy has been the 2007 reform in Mexico City. This reform to the Criminal Code redefined the concept of abortion as "the interruption of a pregnancy after the twelfth week". Therefore, the reform was not decriminalising voluntary abortion; rather, by redefining the concept, the "termination of pregnancy during the first twelve weeks" was no longer a crime. The reform went further to define pregnancy not from conception but from the implantation of the embryo in the uterus wall, hence the day-after pill⁵³ is no longer under the definition of pregnancy or abortion (Madrazo 2009). One month after its enactment, the reform was challenged in the Supreme Court by the ombudsman, president of the CNDH, and the Attorney General of the federal government. One

⁵³ The day-after pill or emergency contraception was integrated to the official package of basic medications in July 2005.

year later, in August 2008, the Supreme Court ratified the Mexico City's health reforms as constitutional.

Since termination of pregnancy has been offered in the City's hospitals, 18.6 thousand procedures have been successfully conducted up to January 2009 (Madrazo 2009). Patients ranged in age from 13 to 46 years old and 86 per cent of them have described themselves as Catholic.⁵⁴ The Mexico City health authorities expected a large number of patients from other states, where induced abortion is illegal; however, up to April 2008, these patients represented only 12 per cent of the total number.⁵⁵ There are no data for procedures in private hospitals and clinics because abortion is still a stigma and socially unaccepted. According to fieldwork findings, private health care providers prefer to keep their "good reputation" than to provide the service or accept that they do offer it. The position of non-profit organisations towards the policy is determined by their own ideas and values; therefore, those that agree with voluntary abortion were the first nongovernmental institutions to provide the service, while faith-based NGOs refused to accept it.

3.6 Conclusion

This chapter provided an overview of the Mexican health system as a backdrop to understanding the two specific policies studied in this thesis. Different service delivery modes are found in Mexico. All of them work independently and only interact in certain spaces, such as advisory councils. That is why the Mexican health system is better understood as one comprised of different sub-systems. The chapter explained how the different health sub-systems work, their main functions, resources, stewardship and financing systems.

The plural character of the Mexican health system introduces a degree of choice and competition. However, the real effects on access and equality of the system are still not clear. The poorer and most vulnerable sectors of society seem not to benefit from this plurality. They have fewer options, since service providers ask for either a fee-for-service or an insurance policy, which the poor are unable to afford. Further studies are needed in order to have a better idea of the implications.

⁵⁴ Interview with Government Official 01/01/2009

⁵⁵ Interview with Government Official 08/05/2008

The Ministry of Health is in charge of general sanitation regulations and of providing services to the share of the population that does not have social security. The public health care sub-system is decentralised and responsibility lies with the state health departments. One of the most important implications of decentralised modes of service delivery is the need for agreement between federal and local authorities in executing health policies. The burden on local authorities to carry out centrally designed policies can be a cause of disagreement or even conflict.

The social security sub-system enjoys a great deal of autonomy from the Ministry of Health and is more powerful in terms of size and budget. There is no separation of stewardship, financing and service delivery functions in these sub-systems, further adding to their independent character. This may explain why there is no strong collaboration between the Ministry of Health and state health departments, and the IMSS or ISSSTE or any other social security institutions. There are some examples of collaboration, such as the *IMSS-Oportunidades* programme, but it was achieved only after complex negotiations. The IMSS's labour union is very powerful and has blocked intended reforms to this sub-system. Also, the public health care institutions are decentralised to state health departments, unlike the social security institutions that are centrally coordinated and managed. The implications of this are very relevant for these institutions' participation in the implementation of health policy. Agreement and collaboration between social security institutions is very limited in the two case study policies, as detailed in Chapter Five.

The role of the private sector in the Mexican health system is becoming more important in terms of use and resources. Private clinics and hospitals are attracting an increasing share of the population, and not just the better-off as previously assumed. Still, there is not enough information available and regulation of the sector is not strong. It is important to understand the key features of the sector in order to consider collaboration with the public health sector. Private health providers follow market mechanisms, and are financed by medical insurance companies as well as by out-of-pocket payments. They are guided by demand for services and profit-making. Unlike private providers, the drive of non-profit health providers is not profit-making, but making services available to people in need. Although they play a very relevant role, very little is known about this sub-system. Participation in public service delivery of both sub-systems could increase access to services for the population. However, there is very little collaboration with the public health institutions. The only spaces

available for interaction are in advisory councils. There are no incentives to enable collaboration or partnerships.

The fragmentation of the Mexican system seems to obstruct stronger interaction and collaboration between sub-systems. Proposed reforms to change this situation have been put forward by the Ministry of Health, but they have not succeeded. The Ministry of Health sees fragmentation as a problem and advocates for an integration of functions in the system, where it can be in charge of stewardship and not of service delivery. Greater coordination and collaboration among the sub-systems may result in a more efficient use of resources and improved access to health care.

The PHI has been the major reform in the health sector in recent years. It addresses one of the major problems identified by health authorities, namely unequal access to health care by different sectors of the population. It aims to bring protection to the otherwise uninsured population that accounts for almost half of the total population of the country. Likewise, the decriminalisation of abortion in Mexico City is a groundbreaking reform in the decades-long fight for reproductive and sexual rights. The effective implementation of these policies depends, among other factors, on the collaboration and concerted efforts of different actors in the health system.

This chapter described the main features of the provision of services in the health care system in Mexico. However, at the time of writing, it was apparent that a new phenomenon was emerging with broader implications for the health system. This was the internationalisation of health systems, especially in the private and non-profit sub-systems. This is taking place too in other developing countries, like India and Thailand, where private health care providers are marketing their services to foreigners and attracting an increasing number of them. In the case of legal abortion, this takes on more significance since women may travel from one country to another in order to have the procedure, such as in the case of Ireland, where women travel to the UK for abortions. The implications of health-related tourism for national health systems are still unknown. Further research is needed in these areas, but this is beyond the scope of this thesis.

The next chapter introduces the main actors that support and oppose the two policies under study. It uses an ACF in order to analyse networks of actors as well as their values and beliefs. This analysis sets the background in order to understand the influence that some actors have on policy implementation.

4 Ideas and policies: advocacy coalitions in health care

Who is involved in advocating and implementing policies? What are their ideas, values and beliefs about the policy? Actors involved in the implementation process, such as politicians, administrators and medical professionals, as well as CSOs that advocate for these policies, are central in determining effective implementation. Some of them may be organised in groups or coalitions sharing the same policy ideas and beliefs. These coalitions use their resources to influence not only policy change, as the advocacy coalitions' framework suggests, but implementation as well. Value-conflict and the politics of agenda-setting do not end with policy design and enactment. Coalitions may constrain the implementation of policies that are based on different ideas and values than the ones they hold. Their members may not be formally organised. In this context, coalitions are better understood as networks.

This chapter uses the ACF to explore and map out the governmental agencies and CSOs, as well as key individuals, who advocate, support and are in charge of executing the PHI and ILE programmes. It addresses the type of relationships among them and how these have been shaped. It also explains the core ideas, values and beliefs these players hold. This is important in order to understand their attitudes and behaviour throughout policy implementation processes. The chapter thus lays the basis for understanding how coalitions, actors and their values and beliefs influence actual policy implementation.

Building on this framework, the chapter goes on to look at the policy areas in which the two policies under study are located and analyse the actors involved in advocating and supporting the policies, as well as the actors opposing them in rival coalitions. The confrontation between rival or competing coalitions does not end with agenda-setting and policy design. The resources of coalitions have to be put to work in order to enable or constrain policy implementation. The ideas and beliefs members share about a policy issue provide the glue holding coalitions together. This chapter explains how coalitions are formed, their characteristics and resources.

The two policy areas I look at are *access to health care* and *reproductive health*. The Popular Health Insurance policy deals with providing access to health services to those outside the social security sub-system. The ILE law is concerned with the realisation of reproductive and sexual rights. Within each area, I identify one dominant coalition and its rival counterpart. Each coalition holds a set of common core and policy beliefs expressed through their proposals and advocacy activities. According to the ideas and values they hold, I name ‘New Public Health coalition’ to the coalition responsible for introducing the PHI from the Ministry of Health. Its competing and rival coalition is the ‘Social Medicine coalition’, based in Mexico City. The latter advocates for a different mechanism to expand health care to the uninsured population. The Social Medicine coalition held important positions in the local Health Department during the 2000-2006 administration, and was in charge of starting the PHI programme in Mexico City. In the reproductive health area, the ‘Pro-choice coalition’ is in favour of decriminalising abortion, while its opponent, ‘Pro-life coalition’, is against it and defends life from conception to natural death. The Pro-choice coalition is based in Mexico City and mainly comprises NGOs with international links. The Pro-life coalition is very close to the Catholic Church and had members in federal government positions also during the 2000-2006 administration.

This chapter is divided into two sections. The first one analyses the two advocacy coalitions within the access to health care policy area, the Public Health and Social Medicine coalitions. The second section looks at the sexual and reproductive health policy area and its two opposing coalitions, Pro-choice and Pro-life. The chapter concludes with a comparison of these coalitions’ resources, explaining how they can be used in implementation processes. The conclusion also raises some issues that the advocacy coalitions’ framework does not address, which are relevant in terms of adequately explaining the Mexican case.

4.1 Access to health care

According to the ACF, a policy sub-system is composed of a substantive dimension, which is the issue-area or sub-system function, plus a geographical dimension or territory where policies may be applied. The PHI programme is about access to health care, hence that issue-area is the policy sub-system or domain that needs to be analysed. The domain can be defined as the space where the conditions for accessing

health care services for the population are debated and set, as well as the rules of inclusion and exclusion of beneficiaries. The second component of the policy sub-system concept is territorial delimitation. In the case of the PHI, the sub-system extends to a national level. The policy is operational nation-wide and the advocacy coalitions in the sub-system have national influence. However, this thesis analyses its implementation in Mexico City exclusively.

The origins of the access to health care policy sub-system can be traced back to the 1970s, when the health system in place started to produce stark inequalities and excluded sections of the population, especially the poor. Critical voices – the incipient advocacy coalitions - reacted to the way the state had been benefiting and privileging certain population groups while excluding others. Under the hegemony of one party, the Institutional Revolutionary Party (PRI), social security, including health care, was used to maintain control over labour unions in particular, but also other organised social groups like peasant and urban organisations. The PRI integrated the umbrella organisation of labour unions, the Confederation of Mexican Workers (CTM), into the party membership. For decades, the CTM was a strong pillar of the party in power. The CTM received in exchange social security benefits delivered mostly through the IMSS. Corporatism characterised the Mexican political system of the time. Corporatist states are defined as having a “form of interest mediation, a formalised system of bargaining between the representatives of the state, labour organisations, and the private business sector” (Samstad 2002, p.3). Schmitter and Lehmburk (1979) define corporatism as “a system of interest and/or attitude representation, a [...] institutional arrangement for linking the associationally organised interests of civil society with the decisional structures of the state” (p.8-9).

The strength of the social security institutions, IMSS and ISSSTE, are examples of the exchange of favours and benefits between labour organisations and the state. As shown in the previous chapter, most of the public spending for health goes to the social security sub-system, deeply undermining the performance of the public health and welfare sub-system headed by the Ministry of Health.

Changes in the worldwide context had an effect in Mexico as well. The move to a primary health care focus in the Alma Ata Declaration in 1978, with more attention given to preventive care and community participation, was echoed by Mexican experts in public health. However, the economic crisis the country endured during the mid-1970s and early 1980s led to public spending cutbacks, especially in

health care (Almada Bay 1990). The attention then turned to reducing costs of services and cost-efficiency. International agencies had an important influence on the plans to reform the health system. It was in the interest of international financial institutions that the Mexican government reduced spending. WHO provided advice in drafting the first National Health Plan for the country in 1974 (Abrantes Pêgo and Almeida 2002ba). The concern of public health experts was to build an integrated national health system able to guarantee universal access to the population and not only to certain sections, as was being done by the social security sub-system.

In this context, opposing advocacy coalitions emerged in the field. As will be explained in the following sections, there are two main coalitions advocating for different ways to achieve universality in the health care system in Mexico: the New Public Health coalition and the Social Medicine coalition. They have marked differences in the ideas and values they hold, but also some similarities. The two coalitions are mainly composed of experts and academics in the field, and are based in research institutions. Their roles and levels of influence have varied through time, one being more dominant than the other. The New Public Health coalition has had a greater influence on health policy than the Social Medicine coalition. However, both have achieved some policy change; for example, the Social Medicine coalition was behind the design and execution of the Free Health Care and Medication programme in Mexico City, and the New Public Health coalition was behind the PHI. The Social Medicine coalition has been more politically active, in the sense of party and electoral politics, while the other has maintained a degree of neutrality. Both of them have strong international links. The background, configuration and resources of the coalitions involved in the access to health care policy-area are explained in the following sections.

The New Public Health Coalition

The New Public Health coalition has been the most influential and dominant coalition in this issue area. The coalition is composed mainly of experts holding postgraduate degrees from American and UK universities and gathers at the National Institute of Public Health (INSP) and the Mexican Health Foundation (Funsalud). They have close connections with power elites, which have opened up political opportunities to influence health policy over the last three decades.

The origins of the coalition go back to the early 1980s when Guillermo Soberón, a biomedical scientist and recognised vice-chancellor of the National Autonomous University of Mexico (UNAM) – the most important academic institution in the country – was appointed Minister of Health in the De La Madrid administration (1982-1988). The main task assigned to the new Health Minister was to re-structure the Mexican health system. He relied on young and promising specialists in health systems and epidemiology to inform the reform project. Coming from the School of Medicine of UNAM and holding advanced degrees from Harvard and Michigan Universities, Julio Frenk, José Luis Bobadilla and Jaime Sepúlveda came on board along with other young scholars. In 1984, Soberón created two Research Centres for Public Health and for Infectious Diseases respectively, from where young experts were able to advise the Minister with scientific evidence for decision-making (Abrantes Pêgo and Almeida 2002a). Leading the Research Centre of Public Health was Julio Frenk, who became the central figure of this coalition.

The group envisioned the creation of a single research institute that would also be in charge of training new generations of health specialists. In 1987, INSP was created as a result of merging the two research centres with the Mexican School of Medicine. Soberón also encouraged prominent business people from health-related industries, like pharmaceutical and private health care services, to set up a civil organisation in order to support scientific research for health reform and policy. Funsalud was established in 1985 as a body to facilitate and promote dialogue among the government, the private sector and civil society. Through the setting up of Funsalud, Soberón's group had a separate space to counter-balance the public research institutions, which were more vulnerable to changes in government administration. In Soberón's words, Funsalud would “attenuate a possible lack of continuity due to presidential administration chronologies” (Funsalud 2005). More than that, both INSP and Funsalud have worked together and grown considerably since their establishment in the 1980s.

The ideological base of this group is found in Frenk's book *La salud de la población. Hacia una nueva salud pública* (“Population's health. Towards a new public health” published in Spanish in 1994⁵⁶). His book brings together previously

⁵⁶ Frenk, J. *La salud de la población: hacia una nueva salud pública*. México: Fondo de Cultura Económica; 1994.

published articles, like ‘The New Public Health’⁵⁷ published in English in 1993, and new ideas in a single integrated work. He acknowledges previous usages of the term “new public health” and explains the differences in those approaches from his own. He decides to keep the term in his work in order to give the idea of evolution rather than change since building on previous works:

What is needed is a formula to integrate the biological and the social, so that successive public health conceptions evolve in an ascending spiral rather than in a circle. This new formula consists of defining a new essence of public health, one that transcends the changing conceptions of historical times. (Frenk 1993a)

Frenk understands public health as both the study and the application of knowledge to a population’s health. He highlights the multidisciplinary aspect of public health and identifies two main research areas: epidemiology and health systems. The first deals with questions about frequency, distribution and determinants of health needs, while the second looks into the social responses to tackle those needs, for example the organisation of the health sector, provision of health care services, financing of the sector and health policies. This division follows the founding by Soberón of two research centres that specifically dealt with these issues and, later, the internal structure of INSP.

The group of experts has not only been advocating but effectively creating extensive and sophisticated information systems in order to inform health policy. Both Funsalud and INSP have been very active in producing, gathering and making available health data, such as the *Núcleo de Acopio y Análisis de Información en Salud* (Nucleus for the Collection and Analysis of Health Data) at INSP⁵⁸ and *Observatorio de la Salud* (Health Observatory) supported by Funsalud.⁵⁹ This group strongly believes in evidence-based decision-making for health policy and reform. Thus, collection and analysis of health data is at the core of their work.

The coalition has been advocating for the core ideas they believe in. Those ideas comprise universal access to health care through an integrated national health system, with separation of functions: regulation, financing and provision (Frenk et al. 2003). They argue that a “structural pluralism” model in health systems can improve

⁵⁷ Frenk, J. "The New Public Health". *Annual Review of Public Health*, 1993; 14: 469-490

⁵⁸ See <http://sigsalud.insp.mx/naais/>

⁵⁹ See <http://www.observatoriodelasalud.net/>

equity, quality of services and provide better distribution of resources. Frenk states: “...we need to move away from false dichotomies and dilemmas as we search for creative ways of combining the best of the state and the market in order to replace polarized with pluralistic systems” (Frenk 1993bb).

The model splits four functions of the health system amongst agencies. The Ministry of Health should be responsible for *modulation*, meaning setting transparent rules for the game. A specific agency should be created to *articulate* between the population, service providers and financing institutions. *Financing* of health care becomes the responsibility of social security institutions that should reach out to the whole population. Finally, *delivery* of services should be catered for by a plurality of agencies so that services can be adapted to health needs (Londoño and Frenk 1997).

They also believe in defining an essential package of services in response to scarce resources. This is a central characteristic of the PHI, as explained in Chapter Three. The promotion of essential packages of services came from the World Bank after the publication of the 1993 World Development Report in which Bobadilla contributed with the background paper ‘The Essential Package of Services in Developing Countries’ (World Bank 1993). He explains that designing the package “introduces a systematic way of analysing information using sound epidemiological and economic methods. [...] Existing information on both disease burden and cost-effectiveness is incorporated into the decision-making process” (p.548). Again, the experts in this coalition show the value of evidence-based decision-making.

The institutionalisation of the coalition’s research activities in INSP and Funsalud proved to be a successful strategic move to preserve their influence on health policy. The close collaboration between these two institutions, one public and one private, has enabled them to continue promoting their ideas. Soberón became the executive director of Funsalud after finishing his term as Minister of Health in 1989. Frenk became the director of INSP and then moved to Funsalud to lead the Economy and Health Studies Series. The exchange of personnel between the institutions, as well as between them and the Ministry of Health, is a common occurrence.

The influence of this group goes beyond national boundaries. Their network extends to the World Bank, the IDB, WHO and the Pan-American Health Organisation (PAHO), as some members have worked at these international agencies or have closely collaborated with them. Bobadilla worked for the World Bank, where he studied the design of essential packages of health services, and provided advice on

health reform to countries in Latin America, Asia and Africa. Frenk collaborated in the making of the World Health Reports 1993 and 2000. Sepúlveda has worked in the Ministry of Health as epidemiology director and vice-minister. He later directed INSP and the National Health Institutes (major health research institutes in the country).

The close ties with the international academic community have been a major advantage for this coalition. The links with international agencies, research centres and prestigious universities abroad has given the coalition a solid legitimacy in scientific research. These links are traced back to the coalition's central figures' postgraduate studies at Michigan University, Harvard University in the US and LSHTM in the UK. Back in Mexico in the mid-1980s, the group invited a selected number of public health academics to be part of an Advisory Committee for the Public Health Research Centre founded during Soberón's administration, and later for the INSP.

The political party neutrality they achieved by focusing on sound scientific research and evidence-based studies paid off when Julio Frenk was appointed Minister of Health in 2000. Given his trajectory, he was considered an expert in public health and health systems. He was not associated with the PRI, as Soberón was. The 2000 national elections ended with more than 70 years of PRI hegemony and introduced the conservative National Action Party or *Partido Acción Nacional* (PAN) to the federal administration. PAN's main social policy interest was health and it took the PHI as their flagship social programme. With Frenk leading the Ministry of Health, the coalition gained direct access to influence health policy and put in practice the ideas they had been working on for years. The PHI policy took in the core ideas of the coalition. A pilot programme started in 2001 in two states and it was then enacted by the federal legislature in 2003.

The coalition has capitalised on this great achievement by publishing several articles about Mexico's health reform experience with the PHI. *The Lancet* published a special issue about it in 2006,⁶⁰ as well as other articles in following years. The INSP has been in charge of carrying out extensive studies and evaluations of the programme requested by the Ministry of Health. One of these studies was carried out in collaboration with the Harvard School of Public Health. Results have also been widely disseminated. As the ACF points out, the use of information as well as

⁶⁰ Julio Frenk and R Horton, 'Evidence for Health-System Reform: A Call to Action', *The Lancet*, 368/9529 (01 July 2006), 3-4.

favourable public opinion are major sources of legitimacy and resources for coalitions. The fact that the same coalition has been evaluating the PHI poses some questions about bias and partiality, but this is not evident to the general public or to those unfamiliar with the coalition's membership and network. Critics of the programme lack the international reach that the New Public Health coalition has and their voices are heard less in the English-speaking world.

The New Public Health coalition has dominated this policy issue-area. Since their origins, they have achieved significant influence while maintaining an overall good reputation. This coalition has thus had most of the resources that the ACF suggests are necessary for successful and powerful coalitions. These include: *formal decision-making authority*, which they achieved through their positions at the Ministry of Health, particularly the appointment of ministers of health; *favourable public opinion*, which they achieved by maintaining their neutrality and carrying out sound scientific research; supply of *information*, which they produce and disseminate to make it available to governments, academic institutions and the general public; *strong financial resources*, which they accrued with the support of private companies through Funsalud and foreign donor agencies and multilateral agencies; and an unquestionable *skilful leadership*, first with Soberón who opened the door to young experts in the field, and then with Frenk, who transformed the coalition's main ideas into real policies. The only resource they lack so far is *mobilisable troops* which, according to the ACF, constitutes an inexpensive resource for political activities like public demonstrations, electoral campaigns and fund-raising. However, this may be explained by the decision of the coalition to maintain a neutral position towards state politics and political parties. They are not interested in engaging in this type of political activity, where support from "troops" is necessary. Their strategy has been to engage with the elites, both in the public and private sectors, who are ultimately the decision-makers. The coalition itself is an elite. Most of its members are from a minority of the population able to pursue advanced postgraduate degrees in prestigious universities abroad. They have used their expertise and knowledge as a source of legitimacy.

The New Public Health coalition has been dominant but not alone. Another group of experts and academics in the same field has also been advocating for their ideas and trying to influence policy. Conflict or confrontation may arise between competing coalitions. The main source of conflict is opposing ideas and values about

the policy issue-area and more specific policies like the PHI and the Free Health Care and Medication programme. The following section analyses the New Public Health rival coalition, the Social Medicine coalition, and contrasts its characteristics to those of that group.

The Social Medicine coalition

The Social Medicine movement has its roots in Latin America and is widespread across various countries in the region. It is an alternative to the mainstream understanding of public health and traditional health institutions. The movement is characterised by a Marxist/socialist ethos on the same lines as other Latin American ideologies, such as the liberation theology (Boff and Boff 1984; Boff 1985; Boff and Boff 1987) and critical pedagogy (Freire 1983, 2003). These ideologies challenge relations of domination. They focus on the oppressed, the poor and vulnerable and seek change through “social justice”. These movements are less known in other parts of the world because most of their work is published in Spanish and/or Portuguese, thus being less influential on international settings where English and Anglo-American ideologies dominate. The origins of the Social Medicine coalition in Mexico is marked by the establishment of the masters programme on social medicine at the Metropolitan Autonomous University in Mexico City or *Universidad Autónoma Metropolitana* (UAM) in the year 1975. This university then became the hub for the Social Medicine coalition in the country. Members of the coalition are well organised in the Latin American Social Medicine Association (ALAMES), founded in 1984.

What defines social medicine is the concern to understand the social determinants of illness. Scholars in the field identify the work of Rudolf Virchow, a German scholar writing in the mid-nineteenth century in Germany, as their main influence. He conducted research on the effects of social conditions on illness and mortality. As the field developed, social medicine students also looked into the effects on health status of policies such as privatisation and public spending cutbacks, occupational and environmental causes of illness, gender differences on health outcomes, and focused their work on social groups such as labour unions, indigenous populations, industry-specific workers (Waitzkin et al. 2001b). Salvador Allende, president of Chile from 1970 to 1973, was a medical doctor and pathologist who greatly influenced the Social Medicine movement in the region. His book *La Realidad Médico-Social Chilena* (The Chilean Socio-medical Reality), published in 1939 while

he was Minister of Health, has become a landmark reference point for the movement. The book defines illness as the disturbance of the individual through social deprivation. It focuses on health problems like maternal and infant mortality, sexually transmitted diseases, emotional disturbances, illegal abortion, as well as looking into housing density as a cause of infectious diseases, and the differences between generic and brand-name pricing of medicines (Waitzkin *et al.* 2001a).

At the core of the Social Medicine group's ideology are the historical and social determinants of the health-disease-care process. They consider the process as a dialectic relation between being healthy, being sick and health care practices, which is determined by social and historical structures. Tajer (2003) explains that one of the main differences with the public health stream is their understanding of populations not as an aggregation of individuals but as collectives.⁶¹ Public health scholars focus on the individual and their characteristics such as age, gender, income, education, and so on. Social medicine, in contrast, focuses on categories such as social class, economic production, culture, and so on. Waitzkin, Iriart *et al.* (2001a) explain that social medicine understands health and illness as a dynamic process rather than a dichotomy, and consider contexts by observing the effects of social conditions over time.

Social medicine is against the privatisation of health care and the participation of private health care providers. It believes that the State has the responsibility and obligation to provide health care to all of its citizens without discrimination. This coalition is critical of current economic relations and is against capitalism and neo-liberal policies. Social medicine advocates consider themselves activists and seek close ties with popular movements.⁶²

The institutionalisation of the Social Medicine coalition came with the establishment of postgraduate programmes in Mexico and Brazil in the 1970s and later with the founding of ALAMES. The Association was created following a series of seminars and conferences organised by Argentinean physician Juan César García, who supported the movement from the PAHO. In Mexico, the coalition has been led by Asa Cristina Laurell and academics like Catalina Eibenschutz, Carolina Tetelboin,

⁶¹ In order to differentiate themselves from the public health movement, they have used the term 'collective health' instead of 'public health'. In Brazil, for example, the Social Medicine coalition has called itself 'Collective Health'.

⁶² Asociación Latinoamericana de Medicina Social, <http://www.alames.org/> accessed 05/01/2011

Mariano Noriega, Jose Blanco Gil and Olivia López (Waitzkin et al. 2001b). They frequently travel to other countries in the region to teach and collaborate in academic research. The UAM, where the group has been based, publishes the journal *Salud Problema* (Health Problem) to disseminate their work.

In Mexico, the coalition has been active in studying workplace health and community development, as well as health policy and systems. For example, Laurell and her colleagues have studied the health conditions of workers in the electric, metallurgical and petrochemical industries. They have also looked into health reform and the effects of economic crises on wellbeing. The group has opposed privatisation of health care and have criticised policies supported by the World Bank and the New Public Health coalition. They have also highlighted the adverse effects of opening up the national economy through NAFTA, by focusing on occupational and environmental health risks posed by large corporations established in the country after the trade agreement (Laurell 1997; Laurell 2000).

The coalition has been more actively engaged in political activities and has close ties with the PRD (Party of the Democratic Revolution). The party has governed Mexico City since 1997, but the real political opportunity for this coalition came when López Obrador was elected Chief of Government for Mexico City in 2000. Laurell has a close link with Obrador and so, given Laurell's trajectory in the field, Obrador appointed her as Head of Mexico City's Health Department. Laurell had the opportunity to put her ideas into practice and introduced the Free Health Care and Medication programme that became the flagship policy of Obrador's administration (2000-2006).

In line with Social Medicine ideology, Laurell removed the fees-for-service system and replaced this with free health care provision (at the point of service) in the city's public health facilities, managed by the Department of Health. The programme "guarantees that all services offered in Mexico City's health care facilities will comply with the concept of equal access to services given the same need. Emphasis is put on collective care for the whole population..." (Laurell 2003). By 2006, the last year of Obrador's government administration, the Free Health Care programme was enacted as a law in order to secure continuity in subsequent administrations. However, the introduction of the PHI policy by the federal government, and the change in local administration (although from the same party), meant that Laurell's policy was no longer central, and its importance diminished greatly.

Access to influential academic journals with wider-audiences has served to provide legitimacy and authority to the ideas of advocacy coalitions. Since PHI became the mainstream health policy and major health reform, the Social Medicine coalition has become one of the few critical voices of it. Most of the coalition's members only publish in Spanish, addressing a mostly Latin American audience, and therefore little is known about their views of the PHI policy. However, not only is language an issue, but their critical stance towards mainstream paradigms as well. Laurell wrote an article in English for *The Lancet* as a response to the series about the Mexican health reform this journal published in 2006. According to her, it was rejected so she sent it to the *American Journal of Public Health*, where it was published.⁶³ Another journal that does publish works from the Social Medicine coalition is the *International Journal of Health Services*.⁶⁴

In Laurell's response to Frenk and his colleagues' series of articles about the PHI, she argues against the policy. One of the main criticisms she mounts is about the introduction of market mechanisms in the form of plurality of service providers and the separation of financing and service delivery functions. She argues that private contracting undermines the authority of state health departments to steer health policies (Laurell 2007, p.520). According to her, the PHI violates Mexican citizens' right to health protection because it conditions access to health care to "purchasing an insurance and paying a premium [...] and restricts health services to a limited number of interventions" (p.521). Laurell highlights several of PHI's weaknesses, for example, the difficulties for families and state governments to pay their respective contribution; insufficient infrastructure and staff to guarantee services; and distributional effects, whereby the re-distribution of health expenditure favours the PHI at the cost of the social security institutions.

The two coalitions in the access to health care sub-system differ in their ideas and policy beliefs. They have different understandings of health and illness, and have opposing approaches towards addressing public health issues. Their differences may be captured in the dichotomy of the individual versus the collective. While the Social Medicine coalition focuses on collectives and social categories, the New Public Health coalition centres on the individual. They also have different strategies towards

⁶³ Interview with Asa Cristina Laurell, 24/03/2008.

⁶⁴ See Asa Cristina Laurell, 'Health System Reform in Mexico: A Critical Review', *International Journal of Health Services*, 37/3 (2007), 515-35.

policy advocacy and influence. While the Social Medicine group is more politically active, supporting the PRD, the New Public Health coalition has maintained a neutral stance towards political parties and instead has nurtured links with economic and political elites. However, both coalitions have managed to directly influence health policy, but only when their leaders held powerful decision-making positions in government.

Opposing coalitions can be found in different issue areas. They are not exclusive to the issue of access to health care. The next section analyses another policy area in health, that of reproductive and sexual health. It shows how rival coalitions work, their resources, and ideas and beliefs, in order to come to a better understanding of their influence on public policy.

4.2 Reproductive health

Access to health care and reproductive health policies are the areas within the health sector where Mexico has experienced major changes in the last three decades. However, the ILE law is not only related to the health sector, but is located at the intersection of two policy areas: reproductive health and sexual rights. One is dominated by medical science and the other by law and human rights. The fight for improved women's health care services and family planning has developed hand in hand with the fight for women's rights and, later, reproductive and sexual rights. Therefore, this policy sub-system is complex and multi-dimensional, touching also upon the individual's values and beliefs and socio-cultural norms about family and the role of women. The debate about sexual and reproductive rights in Mexico has been expressed through three policy domains, namely the fight to decriminalise abortion, the struggle for HIV/AIDS patients to access health care services and, to a lesser extent, the fight for equal civil rights by the gay community. I focus on the abortion debate and look at the Pro-choice coalition and the rival Pro-life advocates; however it is important to recognise that Pro-choice advocates also participate in other policy domains.

The issue of women's rights became the centre of attention when the first UN World Conference on Women was held in Mexico in 1975. The participation of young feminists in the conference led to the drafting of the first ever law project for "voluntary motherhood" in the country, which included the decriminalisation of

abortion, among other issues like sexual violence against women and gay rights (Marcos 1999). Even though the project was discussed in Congress, it was soon put aside. Mexican politicians were not receptive to feminists' claims at the time. Against those claims stood the Catholic Church, a very powerful political actor in Mexico.

The reproductive and sexual rights issue area is highly controversial since it deals with personal and sensitive values and morality; hence, it tends to polarise positions. Two main forces clash in the debate of this policy sub-system: a progressive left-wing position, where the feminist movement stands, and the conservative perspective that follows right-wing Catholic hierarchy teachings and the Vatican position. In 1999, the case of a teenage girl named Paulina became emblematic of this debate and polarisation. In the state of Baja California, the 13-year-old girl was raped by a burglar in her own home. Even though the state legislation allowed for abortion in cases of rape, she was refused the service by public health care providers on the grounds of conscientious objection (Lamas and Bissell 2000). Her case was widely covered by the media, sparking a debate in society about abortion laws and human rights.

The feminist movement strongly advocates decriminalisation of abortion. It originated in Mexico City in the early 1970s and it subsequently spread to other parts of the country. However, the city has remained the stronghold of the movement, with a more progressive and liberal society compared to the rest of the country. The left-wing PRD party has governed Mexico City since 1997. The local Assembly of Representatives has enacted the most progressive of reproductive and sexual rights policies in recent years, namely the decriminalisation of abortion in 2007 and same-sex civil marriages in 2009. Apart from being the largest urban conglomerate in the country, the cultural change experienced by society has been influenced by waves of political exiles who were forced to leave their country because of political repression. Examples of such political exiles are republican Spaniards, who left their country during the 1930s civil war and Franco's dictatorship, and socialist Chileans who left Chile in the 1970s as a consequence of Pinochet's coup d'état, ousting President Allende from power. Many of them have greatly influenced the society of Mexico City, from academia to the arts.

On the other side of the debate, the right-wing Catholic Church takes the lead. Conservatism in Mexico revolves around the Catholic Church and the institutions it supports. Mexico prides itself in being a democratic and secular state. However,

church-state relations have been tense in particular moments in history. First, in the second half of the nineteenth century, the government passed a series of bills known as the ‘Reform Laws’ to cut down the political and economic power of the Church. Then, during the Mexican Revolution and the signing of a new Federal Constitution in 1917, which still rules today, further anti-clerical laws were incorporated. These banned priests and nuns from engaging in political activity, such as voting and standing for election, and even from preaching in public spaces. Such strict norms were enforced only briefly in the late 1920s and early 1930s, sparking a civil uprising known as the *Cristeros* war. The Church and state remained apart until 1992, when the Constitution was amended and formal relations with the Vatican and religious institutions were re-established. Regardless of this separation of church and state, Mexican society and culture has been deeply influenced by and intertwined with Catholic traditions, values and ideas, and the Catholic Church.

Competing coalitions within this policy sub-system comprise the Pro-choice coalition, mostly made up of feminists supporting women’s right to choose over their motherhood, and the Pro-life coalition lead by the Catholic Church hierarchy, which defends the idea of human life existing from conception to natural death.

The Pro-choice coalition

The Pro-choice coalition has been able to directly influence policy through well-planned advocacy actions, as well as through its prominent members when they occupied a political decision-making position. The first major policy change regarding abortion legislation in Mexico City took place in 2000 when Rosario Robles, a feminist leader, was Chief of Government for the city. Although the Robles Law, as the policy is commonly known, did not introduce full decriminalisation of abortion, it paved the way for the ILE law in 2007. In this year, reform was achieved through advocacy by the political party in a majority in the local congress, a party supported by coalition members.

Stemming from the feminist movement, the Pro-choice coalition is characterised by informal alliances among prominent feminists, as well as formal collaboration between CSOs like the Information Group on Reproductive Choice or *Grupo de Información en Reproducción Elegida* (GIRE) and *Católicas por el Derecho a Decidir* (CDD) or Catholics for a Free Choice. Members of the coalition are activists, academics, politicians and intellectuals, and most of them active since

the 1970s. The fight to decriminalise abortion became emblematic of the feminist movement.

In addition to forming NGOs, the informal networks and relationships among elite women has helped to move the pro-choice agenda further in a context where the feminist movement had become fragmented. During the 1980s and the first half of the 1990s, the feminist movement in Mexico was characterised by “its internal conflicts, jealousies, and poorly resolved competitions...” (Lamas 1998, p.106). Several organisations and networks had been created, such as the *Coalición de Mujeres Feministas* (Feminist Women Coalition) and the *Frente Nacional por la Liberación y los Derechos de las Mujeres* (National Front for Women’s Rights and Liberation). However, they had not been effective in influencing public policy. Participation in international UN conferences in the 1990s helped to bring together individual feminists towards clearer political and policy goals. The first UN Conference on Women held in Mexico in 1975, the 1994 Population Conference in Cairo and the Women’s conference held in Beijing in 1995 were central in developing and consolidating the Pro-choice coalition. The Mexican delegations that participated in these conferences were made up of prominent women in government positions, legislators, political party members, as well as civil society leaders (Medina 1995).

Informal relationships rather than legally constituted civil organisations may be more effective in fragmented and competitive contexts, as was the feminist movement in Mexico. Within the Pro-choice coalition, an elite group of seven women that had been working informally, based on personal communication and interaction rather than institutionalised links, extended the coalition’s network to influential and powerful positions. They also brought the Pro-choice agenda to public awareness and debate even though the group only made a few public appearances in 1993 and 1994. Called *De la A a la Z* (From A to Z), the group envisioned itself as a reference point for feminist activism and influencing policy (Lamas 1998). In order to have a political balance, the group was originally comprised of two members of the PRI (centre-left), two from the PRD (left-wing), that have traditionally been supportive of feminists claims, and three independent activists. Marta Lamas, central figure of the group, explains that “an alliance with members of PAN was impossible [...], since the dogmatic and moralizing ideology of the PAN is totally opposed to feminism” (Lamas 1998, p.108). All of them are prominent women, very active in their own areas, and had participated in the UN conferences of 1994 and 1995. Regardless of the group’s

brief public activities, this elite network is connected to most policy changes in favour of reproductive and sexual rights. Although these women have moved from one organisation to another, they have preserved their feminist ideas.

Marta Lamas has kept her independence from political party-activism and works from academia; she has provided an intellectual base for the Pro-choice coalition in several publications. Cecilia Loría entered the group as a well-known NGO leader with a trajectory of work with poor women and indigenous communities. Patricia Mercado joined as an independent activist with trade unions women's associations, but later entered electoral politics. She has founded three different political parties and was a candidate for *Alternativa* Party in the 2006 presidential elections. Amalia García and Rosario Robles are outstanding members of the PRD. García was leader of the party from 1999 to 2002 and governor of Zacatecas from 2004 to 2010; Robles was Chief of Government for Mexico City in 1999-2000 and leader of the PRD from 2002-2003. From the PRI, Teresa Incháustegui and Laura Carrera joined the A to Z group; however because of internal ruptures in the party, both of them left later on. Incháustegui became an academic and is linked to the PRD. Carrera turned to the right-wing PAN, where she led women's groups within the party. All of them have passed through public administration positions at national and local levels, for example the Institute for Women and the Social Development Institute, where they have been able to push the pro-choice agenda forward and influence policy implementation.

The Pro-choice coalition needed reliable and scientific information to advocate in favour of reproductive and sexual rights, specifically on abortion, and to counter-balance the effect of conservative anti-abortion campaigns. Information is a key resource that coalitions may use to influence public opinion and win debates with rival coalitions. Marta Lamas recognised this and, in 1992, together with Patricia Mercado, Consuelo Mejía and Lucero González, founded GIRE. This NGO has been a fundamental actor in the reproductive rights issue-area; they provide information to decision-makers like legislators and executives, as well as to health care providers and other civil organisations working on these issues. GIRE uses a scientific, secular and democratic discourse that appeals to broader audiences rather than just the feminist audience. It focuses on the exercise of citizenship, which includes reproductive rights self-determination. GIRE aims "to transform cultural values and legal norms in relation to sexual and reproductive rights" (Lamas 1997) through research,

dissemination of information and advocacy. After some years of working in GIRE, Mercado left to form the *Alternativa* political party, for which she ran as presidential candidate in 2006, taking the Pro-choice agenda to the debate in electoral campaigns. Mejía also left GIRE to become the director of CDD in Mexico.⁶⁵

The professionalisation of activities in civil organisations like GIRE has been characteristic of this coalition. Feminist groups institutionalised their activities by setting up NGOs, especially during the 1990s, when the country was also fighting for democratisation and more space for civil society participation in decision-making. The Consortium for Parliamentary Dialogue and Equity (*Consorcio para el Diálogo Parlamentario y la Equidad*) illustrates this kind of organisations. In 1998, three feminist groups came together to form the consortium with the goal of opening formal communication channels between women's organisations and legislators, and to lobby for gender equity.⁶⁶ Another example is ANDAR (*the National Alliance for the Right to Choice*) that brings together individuals and organisations to promote the realisation of sexual and reproductive rights⁶⁷.

The participation of international NGOs in the Pro-choice coalition has been a key factor in its influence and survival. Not only do they provide financial resources, but they also generate and disseminate information, provide training to public health practitioners and, in some cases, they also engage in direct service provisioning. Their work has been determinant in the fight for the realisation of sexual rights. These organisations include IPAS Mexico, IPPF, and the Population Council. The Pro-choice coalition has also been widely supported by American donors like the Ford and the McArthur foundations.

The Pro-choice coalition in Mexico City had its first major achievement with the Robles Law, enacted in 2000. It allowed access to abortion, as explained in Chapter Two, in cases where a woman was inseminated without her consent, when there is a threat to the woman's health, and when there are genetic and congenital conditions affecting the foetus. This achievement set the precedent for the 2007 ILE law and was only possible because Robles, a member of the core group of the coalition, was the interim Chief of Government in Mexico City and had the support of a PRD-majority in the local Assembly of Representatives. The links between the

⁶⁵ Interview with Catholics for a Free Choice Mexico director, 30/04/2008

⁶⁶ <http://www.consorcio.org.mx/site/> accessed 08/05/2010

⁶⁷ <http://www.andar.org.mx/> accessed 08/05/2010

coalition and different political parties has paid off. Feminist groups supported the PRD in the 1997 local elections and Cuauhtémoc Cárdenas was voted Chief of Government. He made an agreement with the feminist groups to incorporate their demands on reproductive rights into his government action plan. Nonetheless, he failed to keep his promise and did not call for the appropriate policy changes (Lamas and Bissell 2000). Although voluntary motherhood is in the party's manifesto, according to Lamas and Bissell (2000), Cárdenas and the PRD did not push the agenda because they feared being labelled as pro-abortion so close to the general national elections. He left the city's government seat in 1999 in order to run for the presidency in the following year's historical elections.⁶⁸ Robles stepped in as interim governor for less than a year, but that was enough time for her to make the necessary changes and push forward the feminist agenda.

The most important and celebrated success of the coalition is the 2007 reform that allowed for “legal termination of pregnancy” during the first twelve weeks of pregnancy. For this, the concerted work of a group of five NGOs and its successful advocacy strategy with local legislators was crucial. GIRE, IPAS Mexico, Gender Equity, CDD, and the Population Council collaborated and worked as a team in achieving the reform. This alliance of NGOs worked closely with local legislators in Mexico City in drafting the bill. The approval/confirmation of the local legislature was determinant, since the PRD held an absolute majority together with other smaller left-wing parties. Again, links with the core group of the coalition were crucial. It was Patricia Mercado's *Alternativa* party that presented the law project to the assembly and mobilised a coalition of left-wing parties to support it. The political context was favourable since general elections had just taken place the year before. The law project was discussed in the local legislative assembly (ALDF) for several weeks and was approved by a majority vote in April 2007. The important role of the NGO alliance was recognised by Leticia Quezada, PRD legislator and President of the Gender and Equity Commission in the local congress: “without them we wouldn't have been able to make this law”⁶⁹ (GIRE 2008). Quezada is a strong supporter and advocate of voluntary abortion within and outside the PRD.

⁶⁸ First time presidential elections were organised by citizen-led autonomous institutions, which meant a real possibility to take the PRI out of the presidency after more than 70 years.

⁶⁹ Interview with Leticia Quezada, 16/04/2008

The strategy to expand the Pro-choice coalition beyond feminist groups was very important in order to consolidate their influence. Personal relationships and shared policy beliefs played a key role in integrating the work of the NGOs. Lamas was keen to expand the coalition to include other like-minded NGOs and, together with Mercado and Mejía, took the initiative to invite other NGOs with a pro-choice ethos to form an alliance in favour of reproductive and sexual rights.⁷⁰ They approached IPAS Mexico and Population Council, who agreed to join efforts, and the alliance was formed in the early 2000s. The alliance's strategy was centred on influencing public opinion through the dissemination of reliable information. When the law project was proposed in the ALDF in early 2007, a nation-wide debate between Pro-choice and Pro-life advocates attracted mass media interest. Pro-choice NGOs carefully articulated the messages so as to communicate a focus on health, rights and democracy. They argued that abortion is a public health and social justice issue, and that it is a woman's right to decide whether to terminate an unwanted pregnancy. The coalition effectively used the statement "we are not in favour of abortion but in favour of allowing women to decide on the best course of action for themselves when faced with an unexpected pregnancy" (GIRE 2008, p.38). They avoided irresolvable debates about whether an embryo is regarded as a person, and instead referred to scientific evidence about unsafe abortion. The use of a democracy discourse and a right-based approach was also an effective move in the public debate. Given the history of Church-State relations in Mexico and the recent transition to democracy, they argued for a secular and plural state – demands that resonate with wider audiences.

The conjunctural support of popular and youth organisations, as well as opinion leaders, for the pro-choice NGOs gave leverage for the discussions with legislators. Youth organisations provided *mobilisable troops* for the otherwise middle-class professionals' coalition. Organisations like *Elige* (Choice) and *Decidir* (Decide) joined efforts to have the law approved. They held public demonstrations, where people from very different backgrounds came to the streets to show their support. Public debate and civil participation gained momentum towards the voting date in the local legislature. GIRE's director recognised that decriminalisation of abortion would

⁷⁰ Interview with Catholics for a Free Choice Mexico director, 30/04/2008

not have been achieved without the addition of diverse organisations and support from actors beyond the feminist movement (GIRE 2008, p.42).

Most of the confrontation between the Pro-life and Pro-choice competing coalitions was held in the mass media. Press, radio and television were all engaged in a “war of spots”, while even billboards were used to impact public opinion. The enactment of the ILE law seemed to the Pro-life coalition as a failure on their part as it was unable to block it. However, they are still working to deter their implementation in Mexico City and to prevent the introduction of similar policies in other federal states.

Pro-life coalition

At the centre of the Pro-life coalition in Mexico is the Catholic Church hierarchy. The coalition advocates for the protection of human life from conception to natural death. Mexico is a majority Catholic country. According to the national census of 2010, 83.9 per cent of the population is Catholic. The Church is very powerful and influential given its popular legitimacy and widespread network and resources. The position of the Church even in public policy issues has a great impact on public opinion. An independent national survey carried out in January 2010⁷¹ shows that the Catholic Church is the most trusted institution in the country with 41 per cent of all valid responses, above others like universities (32 per cent), the media (25 per cent), and the Supreme Court of Justice (19 per cent). Politicians are the least trusted by the population, with legislators at 6.2 per cent and political parties at 5.6 per cent (Consulta Mitofsky 2010).

The Church’s hierarchy influences people’s beliefs and opinions from the pulpit and through statements in the mass media. During the weeks before the final vote in the local legislature on the ILE bill, high-ranked clergymen made strong statements against the policy. Cardinal Norberto Rivera, leader of the Catholic Church in Mexico, said it was immoral to resort to abortion in any of its forms, as it was to recommend it or collaborate in the procedure, and that anyone involved was “an accomplice of a seriously evil action”. The Archbishop of Guadalajara, one the most important cities in the country, stated that “science declares, and so does the Church,

⁷¹ The survey had a sample size of 1,000 Mexicans (18 years old or over with a valid voting ID card). Data was collected from private houses in rural and urban locations all over the country. The survey was carried out by Consulta Mitofsky, a private opinion polling company based in Mexico.

that from the moment of conception there is a human being with the right to life until a natural death; therefore abortion, at any stage, for any reason, is the murder of an innocent person. It is a crime, a homicide" (Pérez-Stadelmann 2007).

CSOs, with close links to the Catholic hierarchy, are members of the Pro-life coalition. Their status of "civil organisation" gives them more freedom to engage in party politics. Given the historical context of the Catholic Church in Mexico, the clergy is not allowed to proselytise in favour or against any public policy, political party or politician. Therefore, this kind of CSO plays an important role in extending the political power of the Church. Devoted lay people, who seek to enhance and promote their religious beliefs and values, integrate these organisations. Examples are the *Comité Nacional Pro-Vida* (National Pro-life Committee), *Unión Nacional de Padres de Familia* (UNPF, National Parents' Union), *Colegio de Abogados Católicos de Mexico* (Catholic Lawyers Bar Association), *Asociación Nacional Cívica Femenina* (ANCIFEM, Nacional Civic and Feminine Association) and *Vida y Familia* (Life and Family). Just after the enactment of the bill, the National Parents' Union stated that they were going to make the Mexico City's Chief of Government and the legislators that voted in favour of voluntary abortion pay the "political cost" in the next elections (Simón 2007). Pro-Vida, the most active and perhaps radical of these organisations, organised public demonstrations and media campaigns against abortion decriminalisation. They used harsh images of mutilated foetuses to influence people's opinions. After the bill was enacted, they set up altars and prayed outside hospitals where abortions were carried out. Other organisations set up "information stands" outside these hospitals where they tried to dissuade women from having abortions.⁷²

Like the Pro-choice coalition, Pro-life organisations have important international links. Pro-Vida was founded in 1978 in Mexico while these types of groups were flourishing in the US. The Mexican organisation collaborates with and receives resources from them. For example, information and materials they use in their advocacy and political activities are produced by their US counterparts. Since its foundation, Pro-Vida has opposed state population policies as well as health policies such as the use of contraceptives for family planning and condom-use campaigns to fight the spread of HIV/AIDS (Kulczycki 2007).

⁷² Direct observation March-May 2008 and January 2009.

Religious organisations, especially the conservative Opus Dei and Legion of Christ, are key players in the Pro-life coalition and have also strong international links. These organisations are very close to the Vatican and to economic power elites. They use their position to promote Pro-life values in mass media campaigns. Both Opus Dei and Legion of Christ also promote these values and beliefs through the prestigious schools and universities they manage. Business elites are educated in institutions such as *Universidad Panamericana* and *Universidad Anáhuac*. Members or collaborators of these organisations may occupy important public positions as well as positions with great economic power from where they put into practice their ideas and beliefs. This is the case of Jose Luis Soberanes, member of Opus Dei. In his position as National Ombudsman, he challenged the constitutionality of the ILE law in the Supreme Court of Justice. I explain this further in Chapter Five.

The Pro-life coalition has gained more influence since the right-wing PAN came to power in 2000. PAN is against abortion, as expressed in its party manifesto. This party has been linked to the Catholic Church since its creation and it has a Catholic ethos. PAN legislators and governments advocate for Pro-life policies and against Pro-choice. The PAN in Mexico City participated in the pro-life public demonstrations and backed the unconstitutionality claims presented to the Supreme Court by the CNDH and the Attorney General. PAN also tried to persuade the Mexico City Human Rights Commission to file an unconstitutionality claim, but the local Ombudsman and his Advisory Committee refused to do it.⁷³

Despite losing the unconstitutionality claims against the ILE law, the Pro-life coalition achieved major success in other parts of the country. After the decriminalisation of abortion in Mexico City, it managed to influence local legislatures in other Mexican states towards their Pro-life agenda. In less than three years since the enactment of the ILE law in Mexico City, the coalition secured changes in the laws of 16 states⁷⁴ (from a total of 32 in the country) to protect life from conception to natural death and by giving the status of person to the product of conception, allowing access to abortion only in specific cases, like rape, or not at all. These reforms make policy changes in the future more difficult to achieve.

⁷³ Interview with member of CDHDF Advisory Council, 11/04/2008

⁷⁴ Baja California, Campeche, Chiapas, Colima, Durango, Guanajuato, Jalisco, Morelos, Nayarit, Oaxaca, Puebla, Quintana Roo, Querétaro, San Luis Potosí, Sonora, Yucatán.

Competing coalitions in the reproductive health issue-area are powerful and influential. Unlike the access to health care policy area, there is no dominant coalition here. The Pro-choice and Pro-life coalitions share some similarities and have some differences. Creating NGOs and nurturing informal relationships with decision-makers and like-minded individuals are key characteristics of both coalitions. Pro-choice have managed to influence public policy with the Robles Law and, later, the ILE law. Pro-life advanced reforms to protect life from conception to natural death in more than 15 federal states. Both coalitions have strong international connections with donors, NGOs or religious organisations that provide financial resources and access to information and materials. However, they differ in the way they influence public opinion. Both coalitions are very interested in winning popular support. The Pro-life coalition appeals to people's emotions; they use images and individual cases about women that experienced an abortion to illustrate their arguments. In contrast, the Pro-choice coalition uses a rights-based approach. The language of democracy and citizenship appeals to a wider audience rather than only feminist groups. The Pro-choice coalition also disseminates information generated through surveys and scientific studies in order to avoid arguments based solely on values and morals.

The Pro-life vs. Pro-choice debate has polarised public opinion in Mexico. With the right and left-wing political forces unwilling to reach agreements and compromise, the future of reproductive and sexual rights is uncertain.

4.3 The Advocacy Coalitions Framework applied to the Mexican case

The four coalitions in this study have significant relevance in Mexican politics, especially the health sector, since they have all managed to influence public health policy at different stages. The New Public Health coalition introduced the PHI, and the Pro-choice coalition introduced the ILE. But their competing counterparts have also succeeded in introducing new policies. For example, the Social Medicine coalition introduced the Free Health Care programme in Mexico City in 2001, while the Pro-life coalition managed to reform the laws of 16 federal states to protect life from conception from 2008 to 2011.⁷⁵ Based on their ideas and policy beliefs, each

⁷⁵ Grupo de Información en Reproducción Elegida (GIRE), <http://www.gire.org.mx/contenido.php?informacion=70>, accessed 25/4/2011.

advocacy coalition pushed their agendas forward to the public domain. The factors that determine this influence are best understood through the ACF, which argues that a set of resources support that influence. The way in which coalitions use these resources determines their power to influence public policies, from agenda-setting to implementation and evaluation. Table 4.1 shows a summary of resources available to the coalitions analysed in this study.

Table 4.1 Coalition resources according to the Advocacy Coalitions Framework

Policy sub-system	Access to health care		Reproductive health	
Coalition Resources	New Public Health	Social Medicine	Pro-choice	Pro-life
Formal legal policy decision-making authority	Ministry of Health	Mexico City's Department of Health	Mexico City's governorship Local Assembly of Representatives	Federal government under PAN administration CNDH
Public opinion	Not interested – focused on elites and decision-making authorities	Some – publication of critical articles in newspapers	Very interested – wide range of publications to raise awareness, media campaigns	Very interested – mass media campaigns, Church hierarchy statements and sermons
Information	Generation, collection and dissemination – focus on policy makers and academia	Generation – focus on academia	Generation, collection and dissemination – focus on policy-makers and general public	Some dissemination – focus on general public
Mobilisable troops	No	No	Conjunctural support of other organisations	Conjunctural support of other organisations
Financial resources	Private corporations, foreign donors (foundations)	Some from international organisations	Foreign donors (foundations)	Private donors
Skilful leadership	Julio Frenk	Asa Cristina Laurell	Marta Lamas	No single leader
<i>International links with other organisations*</i>	WB, WHO, IDB	ALAMES	IPPF, Population Council, IPAS	Catholic Church, Pro-life organisations
<i>Informal personal relationships among elites*</i>	Strong	Strong	Strong	Strong
Influence on policy change	PHI programme – National level	ILE Law – Mexico City only	Free Health Care Programme – Mexico City only	Protection of life from conception – sixteen states

Source: Elaborated by author based on interviews with key informants, institutional documents, newspapers articles.

* Resources not included in the ACF

In the Mexican case, having links with organisations outside the national boundaries seems very important, as well as personal relationships held more informally among coalition members and individuals in power positions. These resource categories are not included in the ACF. In order to include these important factors observed in the Mexican case, I have added them to Table 4.1 (in italics). Having links with international institutions and organisations abroad not only provides access to funding, but also to other important resources like information, dissemination channels and training. For all four coalitions, these kinds of links have been crucial. In the case of the reproductive health policy sub-system, informal personal relationships have played a key role in extending the Pro-choice coalition's influence. For the other coalitions, this factor has also been important but not as determinant as in the Pro-choice case. All coalitions have an elite nucleus of leaders that have personal relationships with individuals in powerful positions either in the government, private sector or civil society. These relationships enable alliances, collaboration and support of policy initiatives as the cases in this study show.

The analysis also shows that the two coalitions in the access to health care domain are not interested in public opinion when compared to other coalitions. They have focused on academic research and on influencing power elites. This is relevant when taking their policies to the field, in terms of support from implementers and beneficiaries. This is also reflected in the lack of mobilisable troops that these two coalitions show. They have little or no links with grass-roots organisations that work on the grounds of either health issues, or any other local level issues.

All four coalitions under analysis show the importance of skilful leadership and the key role of individuals or personalities. This finding supports Lasswell and Kaplan's (1950) and Greenstein's (1992) arguments that personalities are central in the policy process. In the case of Mexico, advocacy coalitions have been held together by leaders like Julio Frenk and Asa Cristina Laurell, or by core groups of individuals like Lamas, Robles, Mercado and colleagues. The work of advocacy coalitions cannot be explained without understanding the impact of these individuals, their strong motivation, drive and commitment to the coalition's cause.

4.4 Conclusion

This chapter analyses key actors in the two issue-areas of the case study policies. It does so by using the ACF, which highlights the ideas and policy beliefs actors have. The chapter offers a deeper understanding of the configuration of advocacy coalitions in the Mexican case: their background, leaders, resources and strategies. This is important as it constitutes a basis upon which to explain why actors involved in public policy may support or block its implementation. Coalitions are very powerful and also use their resources to influence policy beyond agenda-setting. The background and interactions of advocacy coalitions is central in understanding their role during policy implementation. Analysing their historical development and trajectories explains current states of affairs. The rivalry between the New Public Health and the Social Medicine coalitions is a clear example. This chapter also explains how the role of key individuals – their values and beliefs - and the informal relationships they hold with other key actors, is very important when influencing public policy.

These coalitions' experiences explain the importance of getting members into formal decision-making authority positions. This factor offers access to power and it has been determinant in all four cases. However, timing is crucial. When competing coalitions hold key positions in the same policy sub-system, especially in government, they may hinder each other's projects and initiatives. The coalitions analysed in this chapter have occupied important positions in the Ministry of Health, Mexico City's Health Department, Assembly of Representatives, as well as in local and federal governments. In the access to health policy sub-system, competing coalitions held respective positions in the federal and local governments at the same time, blocking the other's policy ideas. The same happened in the reproductive health policy sub-system, where members of the Pro-life coalition at the federal government have tried to bring down the ILE law in Mexico City. I discuss these issues in more detail in the next chapter.

The Mexican case shows the relevance for coalitions of having a degree of authority and legitimacy among the population that can be translated into public support. Coalitions within the access to health policy domain gained legitimacy through rigorous academic research and generation of knowledge. They published their work in prestigious academic journals that provide recognition and authority in the field. This shows the importance of information to coalitions. They collect,

generate and/or disseminate information that serves to support their ideas and policy beliefs. Conflicts and confrontation between different policy positions are won by appealing to public support through evidence. However, by focusing on academic research, these coalitions have not developed links with grass-root organisations that could also be an asset for policy advocacy and public support.

This chapter shows that the ACF can be applied to developing countries. However, the framework does not include some factors that the Mexican case reveals. The ACF does not consider the relevance of international links within coalitions and how this may affect their performance in terms of available resources. The coalitions in this analysis receive a considerable proportion of funds and other resources from international organisations or their counterparts based in other countries. Furthermore, these international connections mean that coalitions actually extend across countries, surpassing policy domains that are mainly held within national boundaries. Further research is needed on these issues in order to fully understand the role of advocacy coalitions in a global context.

The following chapter analyses the relations between local and federal governments for implementing the two case study policies. It also explains the degree of involvement of the private and third sectors in service delivery. The chapter addresses the modes of service delivery, which is an explanatory factor in the analytical framework of this thesis.

5 Translating policy into action - policy operationalisation

This chapter looks into the process of translating policies into practice. It addresses the operationalisation level of the policy-implementation process. Operationalisation is where responsible agencies and their functions are defined, agreements between agencies or institutions are written, or norms and regulations are set. The next chapter focuses on the service-delivery analytical level, where the actual provision of services takes place, where implementers meet face-to-face with beneficiaries or service users. All of these actions take place after a policy is enacted or has become a law. The aim of this chapter is to explain how relationships derived from the service delivery arrangements in place (decentralisation, direct state provision, contracting out with private providers, and so on) influence the effective implementation of policies in the case of Mexico City. It addresses the questions of how services are provided to the population and whether private and third sectors participate in service delivery. Building on the previous chapter, this chapter shows the centrality of actors and their ideas in determining effective implementation. The previous chapter provided an analysis of the main actors, their values and beliefs, involved in the issue-areas relevant to the health policies in this thesis. It served as a background to understand how these have had an impact on policy implementation.

This present chapter argues that actors and their ideas are more relevant than the mode of service delivery itself. Whether there is decentralisation, contracting out or private health care provisioning or not, individuals and their beliefs matter the most. Private and third sector providers participate in service delivery based on their ideas, values and beliefs. In decentralised systems, the relationship between local and federal governments is crucial for policy implementation. The individuals holding key positions determine this relationship. They have the power to enable or constrain certain policies. Both case studies here show a conflictual relationship between federal and local governments that constrains policy implementation. These conflicts arise from opposing ideas, values and beliefs, while it becomes clear that rival coalitions occupy positions at the operationalisation level in the policy-

implementation process. In the case of individuals working in the private and third sectors, their participation on policy implementation is determined by values and beliefs such as profitability, reputation and prestige, and support for the ideas behind the policy in question.

The public health care sub-system is the main service provider for both policies under study. As explained in Chapter Three, the Ministry of Health is the head of this sub-system that includes hospitals, health centres and highly specialised institutes. The public health care sub-system is decentralised; therefore, responsibility for its functions (financing and service delivery mainly) lies with each state's health department. State governments have to comply with Ministry of Health regulations, but they also have their own health regulations. This thesis analyses one federal policy and one local policy. The PHI is managed by the Ministry of Health, while the ILE only applies to Mexico City and is, therefore, managed by the city's Department of Health.

The roles of the private and third sectors are relevant when analysing service delivery arrangements. It contributes to policy implementation effectiveness by expanding access to services for the population. In this thesis, private providers refer to market-based, for-profit service providers. By third sector I mean nongovernmental organisations (NGOs) or charities that provide services on a non-profit basis. In the case of the policies studied here, the role played by these sectors is minimal. For PHI, agreements have to be written in order to allow private and third-sectors to participate in the programme. In such cases, policy managers at the state level contract out the provision of services to private providers. The PHI policy aims to introduce "managed competition" among service providers so that beneficiaries can choose a health care provider. For the ILE, the case is different. Health care providers are not required to have a contract with the government. They are able to offer abortion services if they choose to, since it is no longer a criminal act. This chapter explains the reasons why private and non-profit organisations have to collaborate or not in the PHI scheme and offer services under the ILE.

The chapter is divided into three sections. It starts by explaining the effectiveness of implementation for both policies. In order to observe effective policy implementation, the chapter focuses on those aspects primarily affected by service delivery arrangements, that is, access to services. Section two describes the conflicts, and their sources, between the federal and the local governments and their main

sources, within the broader context of the decentralised health system in Mexico. Section three explains the participation of private and non-profit sectors in service delivery and their reasons for contributing or not to policy implementation. The chapter ends with a summary of key points.

5.1 Policy implementation effectiveness

In Mexico City, the PHI and the ILE policies have different implementation outcomes in terms of access and the capacity of implementing agencies to provide relevant services. This chapter focuses on access to services, since modes of service delivery directly affect accessibility. It is argued that the main obstacles observed for the implementation of the PHI relate to accessibility, while for the ILE law they relate to the capacity to provide services. This section explains the signs of (in)effective implementation observed in the two case studies related to modes of service delivery. The reasons for these have to do with clashes between federal and local governments and the poor collaboration with the private and third sectors, as explained in later sections of this chapter.

The first obstacle in putting the PHI into practice in Mexico City was the refusal of the local government to sign up to it. In decentralised service delivery systems, local governments have full responsibility for implementing health policies. In this case, Mexico City's health authorities refused to implement the PHI programme. As a result, potential beneficiaries had no access to this policy's services for a year and a half after it was enacted in January 2004. It took months of negotiation between the local and federal health authorities to finally put the PHI into practice during the second half of 2005.⁷⁶

Since Mexico City is the country's capital, it hosts a number of federal hospitals and specialised (third level) health care institutions. As Chapter Three explained, these are managed by the Ministry of Health and not by the city's Department of Health. The PHI norm states that state-level health departments need to sign agreements with the SSA them so that federal health care units receive PHI

⁷⁶ Laura Gómez Flores, 'El Gdf No Aplicará El Seguro Popular Federal, Señala Laurell', *La Jornada*, Martes 4 de enero de 2005 2005. Fabiola Cancino and Angélica Simón, 'Cede Gdf: Acepta El Seguro Popular', *El Universal*, 04/02/2005 2005. Fabiola Cancino, 'Gdf Acepta Convivir Con Seguro Popular', *El Universal*, Viernes 04 de febrero de 2005 2005.

beneficiaries.⁷⁷ Agreements with federal hospitals increase access to PHI services. The number of agreements signed between federal health care units and Mexico City's Department of Health is another indicator of accessibility. The Health Department did not initiate any negotiation with federal health care units until 2008.⁷⁸ Six agreements were then made with federal hospitals and national institutes.⁷⁹

Access to services may also be extended with the participation of private and third sectors in the provision of these services. As in the case of federal health care institutions, local authorities need to sign an agreement in order to contract services out to private providers. By the end of 2010, no such contracts had been produced; therefore, there was no collaboration between health authorities and private providers. Up to that date, only public health care providers offered services to PHI beneficiaries in Mexico City, thus limiting the number of options available to them.⁸⁰

In the case of the ILE, implementation in terms of access seems to be more effective than in terms of capacity. Most public health care hospitals provide the service, which was available immediately after the law was enacted in late April 2007.⁸¹ Although limited, there is private and non-profit sector participation. A small number of private and third-sector health care providers offer voluntary abortion services that nonetheless increase accessibility and choice for potential patients. At the time of fieldwork, I was able to confirm that several private and third-sector providers were offering voluntary abortion services. At least two NGOs, namely Marie Stopes Mexico and Mexfam, and at least six private clinics provide voluntary abortion services in Mexico City.

Federal authorities threatened to limit access to voluntary abortion services only one month after the enactment of the new law in April 2007. The federal level Ombudsman and the General Attorney put forward unconstitutionality claims of the ILE to the Supreme Court of Justice. They argued that Mexico City's legislature had violated the Federal Constitution with the ILE, and that the law should therefore be revoked. This judicial process was the most important factor in not only hindering, but

⁷⁷ Reglamento. Sistema de Protección Social en Salud.

⁷⁸ Interview with government official, 12/03/2008.

⁷⁹ Secretaría de Salud del Distrito Federal,
http://www.salud.df.gob.mx/ssdf/seguro_popular/index/convenios.php accessed 17/04/2011

⁸⁰ Secretaría de Salud del Distrito Federal, http://www.salud.df.gob.mx/ssdf/seguro_popular/ accessed 17/04/2011.

⁸¹ Ella Grajeda, Mónica Archundia, and Ricardo Cruz, 'Inició Ya La Práctica De Abortos, Indica Salud', *El Universal*, Martes 08 de mayo 2007.

bringing the implementation of that policy to a complete halt. Although it did not accomplish its objective, the legal process lasted for more than a year and this uncertainty, as observed during fieldwork, constrained both public and private providers from fully implementing the policy.

The division between local and federal health care providers has also restricted the implementation of the ILE policy. Federal authorities refuse to provide the services in their hospitals and health care units located in Mexico City. This means that people covered by the social security institutions like IMSS and ISSSTE cannot have voluntary abortions in their hospitals and clinics.⁸²

The two case study policies in this thesis have different implementation processes, yet conflicts between federal and local authorities are observed in both of them. These conflicts are not an effect of decentralisation *per se*, but can only be present in decentralised systems. The following section explains the sources of these conflicts in the Mexico City case.

5.2 Decentralisation: federal vs. local governments

Policy implementation studies have been concerned with the reasons why policy objectives and expected outcomes are sometimes not met. Federal regimes, like Mexico, pose a challenge for country-wide policy implementation since, in the first instance, each federal entity has to agree and sign up to the policy. Furthermore, translating a policy into action can be potentially more difficult if it has to move downwards from the federal government to states and municipalities. In such cases, the coordination and division of responsibilities has to be carefully described and assigned. This situation reflects what Pressman and Wildavsky first point out as the implementation problem: “How great expectations in Washington are dashed in Oakland...” (1973). The PHI case is an example of how federal policies do not get through as intended in local settings. The paradox in the Mexican case is that the policy was designed in the country’s capital, Mexico City, and the federal entity that did not wish to sign up to it was also Mexico City. It seems that geographical distance is not an issue but a dispute in ideas and beliefs. With the ILE, a similar situation

⁸² Redacción La Jornada, 'Imss No Cambiará Su Reglamento Para Practicar Abortos: Molinar', *La Jornada*, 26 Abril 2007 2007.

arose, but the other way around: a local policy was enacted at the local level but met with opposition from the federal government.

This chapter argues that the ideas and beliefs of individuals holding decision-making positions in government have a great influence on the implementation process. The risk of decentralised service delivery is that it may create conflicts between the different levels of government. This section looks into the ideas, beliefs and values of federal and local level actors and how they influenced the implementation of health policies. It commences with an analysis of the PHI programme and then continues to analyse the ILE.

The chapter builds on the works of Bourdieu (1990), Lasswell and Kaplan (1950), and Greenstein (1992), who argue that individuals' "predispositions" and their context explain their political response and behaviour. These predispositions include, among other factors, "identifications, opinions, attitudes, beliefs, values, ideology and stereotypes" (Parsons 1995, p.369). Bourdieu names them "dispositions" and they are structured in "habitus" that determine practice, "not along the paths of a mechanical determinism, but within the constraints and limits initially set on its inventions" (p.55). These authors focus on key or central individuals in the policy process. People in these positions not only have a great deal of discretion to favour one policy over another, but in some cases have the power to entirely accept or reject the execution of a previously enacted policy. Hicklin and Godwin (2009) also stress the centrality of individuals and their ideas. They mention that individuals rather than institutions make the majority of decisions that drive policy (p.14).

This section analyses the two case study policies, explaining how key individuals at both federal and local levels of government and their ideas compromised the implementation of these health policies.

Popular Health Insurance (Seguro Popular)

Mexico City was the last of the federal entities to sign up to the PHI programme. This resulted in a delay of a year and a half in putting the policy into action, leaving potential beneficiaries without access to policy services for that period of time. The policy was approved by the federal legislature in 2003 and was due to operate nationwide in January 2004. By mid-2004, most states had signed up to it except for Mexico City, Durango and Chihuahua. The latter two were to hold elections in 2004, so PHI

authorities decided it was better to sign it with the incoming administrations.⁸³ Mexico City only accepted it in June 2005 after long negotiations between federal and local health authorities. The reason given by the government of Mexico City for rejecting the implementation of the PHI was that they were against any payment for health care, as required by the policy, and that they already had a policy that guaranteed their citizens free access to health care and medicines (Gómez Flores 2005).

Mexico City's government's refusal to carry out the policy was the first major obstacle that the PHI encountered in the early phases of nationwide implementation. The reasons behind this were the ideas and beliefs of individuals in key positions of the local government. The strongest opposition to the PHI came from the head of the Department of Health in Mexico City. The Health Department had previously introduced a programme to tackle the same problem as the PHI: the lack of health care protection of about half of the population, also known as *población abierta*. Mexico City's policy, called the 'Free Health Care and Medication programme' (known in Spanish as *Programa de Gratuidad*), was introduced in 2001 and offered services at local health care units that were free to all uninsured citizens living in the City.

The basic principle behind both PHI and Mexico City's programme is enshrined in Article 4 of the Mexican Constitution, which states that "every person has the right to the protection of health...". Both programmes aim to bring health care coverage to the population previously left without any protection by the social security institutions. Mexico City authorities did not challenge, but rather shared, the idea. Nevertheless, the mechanisms that federal and local level authorities devised in order to achieve this are supported on different and even opposing principles and values. This was the source of conflict between federal and local authorities.

Two prominent individuals were influencing/leading the debate, and they could not have been in any more strategic positions at the time to push their own ideas and beliefs forward. From 2000 to 2006, at the top of the Ministry of Health was Julio Frenk, who designed the PHI. At the local level was Asa Cristina Laurell, heading the Department of Health. Both of them have a background in academia and are specialised in health systems and health policy. However, they took very different approaches to health, namely, the 'New Public Health' and 'Social Medicine'. As discussed in Chapter Four, these approaches are in turn based on different values and

⁸³ Interview with CNPSS official, 18/04/2008

principles around health care. For the past two decades, Frenk and Laurell have had a rich academic debate on health systems' reform, where most of their arguments oppose each other. With a new government in place and the introduction of the PHI, these two leaders in health care, situated in different but key positions, were about to clash.

The context in which PHI was introduced was highly political. This policy became the flagship of the federal administration, and it was enacted by the federal legislative just a month before mid-term elections in 2003. The party in power was the conservative National Action Party, or PAN, having won the presidency in 2000 after more than 70 years of Institutional Revolutionary Party (PRI) hegemony. The expectations for the new government were very high. After the PRI defeat in the polls in 2000, both PAN and the PRD tried to gain as much popular support as possible. The PRD has its stronghold in the country's capital, where it has held power since the City was able to elect its authorities in 1997. Controlling the government of Mexico City has given the PRD considerable power, as the chief of government of Mexico City holds the second most important political position after the presidency.

The PHI was enacted in 2003 after more than two years of negotiations and buy-in of key actors and interest groups to support the new health policy. Dr Frenk met and talked to all heads of state health departments to explain what the PHI was about and how they would be involved in putting it into action. The only person with a critical view of the policy was Dr Laurell, head of Mexico City Department of Health. Frenk and Laurell met to discuss the arguments for and against the PHI but they were unable to reach an agreement. Dr Frenk explains: "She [Dr Laurell], the same as me, has decades working on the issue, she knew very well and perfectly understood what I was talking about [...]. The dialogue with her was immediate."⁸⁴ However, she never agreed to the policy and the chief of government of Mexico City backed her position.

The Mexico City government argued against signing up to the PHI policy by saying that it had its own health care policy, which better complied with the Constitutional right to health because it provided open access to health care without restrictions or conditionality. The only criteria for entering the programme were to be resident of the City and not to be covered by any other social security insurance (like

⁸⁴ Interview with Julio Frenk, 22/05/2008

those of IMSS or ISSSTE). Mexico City's *Programa de Gratuidad* was launched in 2001 shortly after Laurell's entry into the Department of Health. In 2006, the programme was approved by the local legislature to become a law in order to survive administration changes.

Laurell's position was more individual than institutional. Her political party did not hold an official position about the PHI and many party members were actually in its favour.⁸⁵ The opinion on that policy within the PRD was divided and, at the moment of voting in the Federal Congress, half of the PRD senators voted in favour, while all of the PRD lower-chamber members voted against the health reform. During the voting session in the Senators' chamber, the president of the Health and Social Protection Commission at the time (from the PRD) argued against the reform. He stated clearly that it was his *personal* view and not the position of his party:

I'd like to say, because it is very important to tell you, I'm not speaking on behalf of the Democratic Revolution Party, because we had as a party a very intense debate, and in this intense debate we had, there were confronting views.⁸⁶

Also, other states governed by the PRD like Michoacán, Baja California Sur and Zacatecas did not oppose the reform and signed up to it at the start of its implementation in 2004, as stated by the law.

The ideas of the individuals leading the debate around the PHI and its implementation in Mexico City are based on different approaches to public health. Laurell and Frenk's conflicting ideas are observed in the health policies they pushed forward while holding key decision-making positions. They come from different, and at times opposing, values and beliefs that are difficult to change or compromise. Table 5.1 shows a summary of the main differences in ideas between federal and local health authorities.

⁸⁵ From 16 PRD Senators, 7 voted against the reform. The total Senate voting in favour of the reform was 83, with seven against. Source: Senado de la República: www.senado.gob.mx accessed 17/02/10

⁸⁶ Registro estenográfico. Sesión ordinaria LVIII Legislatura 24 Abril 2003. http://www.senado.gob.mx/servicios_parlamentarios.php?ver=estenografia&tipo=O&a=2003&m=4&d=24 accessed 17/02/2010

Table 5.1 Summary of concepts and opposing ideas between federal and local level health authorities 2000-2006

	Federal level – Frenk at Ministry of Health	Local level – Laurell at Department of Health
Right to protection of health	Individual entitlement (individual portability)	Social right – citizenship status
Policy outreach	Targeted strategy to reach the poor, gradually universal	Universal access
Service coverage	Pre-defined package of services	Universal coverage of available services
Fee for service	Payment of annual premium according to income level	Free at point of service
Financing	Financial restructure – tripartite: Federal, local governments and families	Financed through general taxation
Subsidy	Subsidise demand – funds follow consumer	Subsidise supply – funds allocated to providers
Quality of services	Managed competition	Strengthen public institutions
Service delivery	Plural provision, contracting out	Public provision
System functions	Separation of financing and delivery functions	Integration of functions
Allocation of resources	Market – subscribed families (demand)	Welfare state – according to need
Choice	Consumer sovereignty – able to choose provider	Single provider – the state
Access	Voluntary insurance – opt out option	Services available to all

Source: Elaborated by author based on face-to-face interviews, papers and published interviews with Frenk and Laurell

These ideas are based on the New Public Health and Social Medicine ideologies. Supporters of the New Public Health, from the Ministry of Health, promoted the PHI with Julio Frenk as leader. In Mexico City's Department of Health, Asa Cristina Laurell and supporters of the Social Medicine movement opposed the policy. As Chapter Four explained, the New Public Health coalition argues that service provision should be plural, with the participation of the private sector, where providers could compete to attract patients. In this way, public funding follows service users that, in turn, choose a provider. It proposes to separate funding from service delivery in order to improve performance. In contrast, the Social Medicine coalition holds that the welfare state should provide health care to its citizens. Public funds are allocated to service providers in order to strengthen the system as a whole; there is no competition

among them. In this view, the system integrates funding and service delivery functions.

Payment for services and coverage of services were at the core of the debate. Laurell believes that services should be free for all and with universal coverage. Frenk believes in covering a pre-defined package of services in order to optimise resources. Beneficiaries should pay an annual premium according to income level to show they value the services received. In Frenk's view, the right to health care is exercised individually. For Laurell, this right is given by citizenship and is universal. These ideas are very difficult to change or reconcile as they are not easily proven right or wrong with evidence. They are at the deep core of belief systems; as explained in Chapter Four, deep-core beliefs are the most difficult to compromise. The clash of deep-core beliefs is the source of value conflict in policy-making, as this case shows.

Political and public-opinion pressures on the Mexico City government started to mount from the beginning of 2005, when all states had already been implementing the PHI for a year or more. News sources in the country highlighted the story, pointing out that people in Mexico City were being left out of the benefits of PHI policy. The Federal Congress issued an official request to Mexico City's authorities to sign up to the agreement. Mexico's President Vicente Fox announced that the Ministry of Health would implement the PHI in Mexico City through the federal hospitals and national health institutes located in the City. All of this was putting pressure on the local government. But perhaps the greatest political pressure came from the process of lifting immunity from prosecution to the Chief of Government of Mexico City at the time, Andrés Manuel López Obrador. His intentions to run as presidential candidate for the PRD in the 2006 elections were halted during this *desafuero* process. This meant that, if the immunity privilege was lifted, he would be prosecuted by a federal court on charges over the construction of a road on expropriated land, and he would not be able to run for the presidency.⁸⁷

⁸⁷ López Obrador was the favourite candidate of the left-wing party the PRD to run for the presidency in 2006. The right-wing PAN, holding the federal government, saw a real threat in López Obrador. He was accused of breaching a court order after allowing the construction of an access road to a hospital that went through a disputed plot of expropriated land to continue. As chief of government of Mexico City, he enjoyed immunity of prosecution, therefore, the federal legislature voted in favour of lifting his immunity so he could be charged. If prosecuted, Obrador would have been unable to run for the presidency. However, the legal process was halted by President Fox due to the widespread civil support to López Obrador. BBC News, "Mexico mayor stripped of immunity", 2005/04/08, at <http://news.bbc.co.uk/1/hi/world/americas/4422935.stm>.

The Mexico City government gave in and opened a window for negotiation with the federal government. The local Department of Health finally accepted implementing the federal policy after months of negotiation. The local health authorities and the federal PHI Commission met in three rounds of negotiation. The main concerns for implementing the policy were about technical and legal issues, and the affiliation process. The fact that financial resources would be coming from the federation was a key issue in persuading Mexico City's health authorities to accept the programme. "We demonstrated that the City would receive substantial resources, *substantial resources*, that would enable them to offer wider services to those eventually covered [by the programme]."⁸⁸

After several months, they finally reached an agreement. Mexico City would put the PHI into practice but only under certain conditions. The PHI policy would have to co-exist with the local *Programa de Gratuidad*. Laurell rejected the idea of charging a premium to beneficiaries, as the PHI establishes that only those in the lowest levels of income are exempt of paying; therefore, the Department of Health agreed to accept only people exempt from this payment. The Department also refused to have a separate body coordinating the programme and managing the financial resources for its implementation. Instead, PHI monies were to be managed by the Finance Office within the Department of Health. By pooling all resources together, monies could be used as they saw fit and not necessarily for PHI implementation. Laurell expresses: "We don't sell our principles in the money market."⁸⁹ It was important for her to keep certain values and not to compromise them. By refusing to sign up to the PHI, the Mexico City government would have forfeited an equivalent of nine per cent of its total budget for health that would have come through this programme.

During the rest of López Obrador's administration, the PHI received very little attention from the Department of Health. Nevertheless, they managed to comply with the negotiated goal of registering 100,000 families. In the end-of-term report of activities, Dr Laurell states:

After one year and six months of signing the agreement to implement the Popular Health Insurance in Mexico City, the Mexico City

⁸⁸ Interview with member of PHI commission involved in negotiations with Mexico City authorities, 20/05/2008. Emphasis and repetition in original interview.

⁸⁹ Interview with Asa Cristina Laurell, 24/03/2008

government has complied with the commitments set in agreement with the federal level; nevertheless, it continues to have a critical position towards the idea and operation of the System for Social Protection in Health [Popular Health Insurance]. In contrast, it sustains as central policy the Free Access to Health Care Services and Medicines to the population that lacks social security, as well as the responsibility of the government to guarantee them.⁹⁰

The PHI policy seems to be better implemented with the new administration (2006-2012), even though it is a government from the same political party, the PRD. In Mexico, it is common that, with administration changes (especially if there was a change in political party too), heads of government departments, and sometimes managers as well, are dismissed. This was the case in 2006 in Mexico City's Department of Health. Individuals in key positions were replaced by people closer to the federal administration. The appointed head of the Health Department, like others in strategic management posts, came from the federal level. The new Co-ordinator for the PHI, for example, had previously worked in the National Social Protection in Health Commission (in charge of the national coordination of the PHI) and had worked directly with Julio Frenk for many years.⁹¹ This move was determinant in promoting the implementation of PHI in Mexico City. The perception of key informants is that, with the new administration and Marcelo Ebrad as Chief of Government, the communication and collaboration between the Ministry of Health and the local Department of Health improved considerably. One interviewee expressed that “the [new Health] Secretary cleaned the house”⁹². New channels opened up to sign collaboration agreements between federal health care units and the Department of Health. From 2009 to date, there have been six agreements between the Health Department and federal health care institutions, comprising three hospitals and three national institutes.⁹³

With people supporting PHI, as well as being in charge of implementing it, the programme has been growing. The previous administration had 100,000 families affiliated to the programme. Under the new administration, that number reached

⁹⁰ Secretaría de Salud del Distrito Federal, 'Informe De Trabajo 2000-2006', (México DF: Gobierno del Distrito Federal, 2006). p.36.

⁹¹ Interview with PHI director for Mexico City 12/03/2008

⁹² Interview with SSDF official, 15/04/2008

⁹³ Hospital General de México in 2009, Hospital Juárez de México in 2010, Hospital Infantil de México in 2010, Instituto Nacional de Enfermedades Respiratorias in 2010, Instituto Nacional de Cardiología in 2010, Instituto Nacional de Pediatría in 2010.

417,000 by 2009; certified health centres increased from 22 at the end of 2006 to 105 in 2009, and all 28 hospitals managed by the Department were certified as well. Federal financial resources increased from 316 million MXN (24 million USD) received in 2005-2006, to 1,470 million MXN (115 million USD) in 2009. Mexico City is the only federal entity that does not receive any resources from beneficiaries because they all belong to the lowest two levels of income, and the PHI norms state that those at these income levels are exempt from paying the annual premium (Comisión Nacional de Protección Social en Salud 2010).

The first obstacle for the implementation of the PHI in Mexico City was the clash of ideas between local and federal levels. Individuals holding decision-making and strategic positions and their values and beliefs were central in putting this policy into practice. Individuals in the Ministry of Health and in the Mexico City's Health Department had very different ideas about the policy issue. These differences halted the PHI's implementation in Mexico City. The change of administration in the City's government also changed this situation. The new government administration opened up collaboration channels with federal level authorities, improving its implementation. The agreements with federal health care institutions increase access to services otherwise excluded to beneficiaries.

Termination of Pregnancy Law (ILE)

Conflict between federal and local authorities in policy implementation is also found in the case of the ILE, or *Interrupción Legal del Embarazo*. Abortion during the first twelve weeks of pregnancy was decriminalised in Mexico City by the local legislature in April 2007. The federal government under the rule of right-wing PAN opposed it and put forward a claim of unconstitutionality before the Supreme Court of Justice. This was the first major attempt to stop the implementation of the local policy. In addition, federal health care institutions, like IMSS, ISSSTE and Ministry of Health hospitals, also opposed the policy and refused to offer the service in their establishments in Mexico City, even though it was legal in that federal entity.

Two claims of unconstitutionality came from the federal level. The first one was put forward by the president of the CNDH, José Luis Soberanes, and the second one by the Federal Attorney General, Eduardo Medina-Mora, one month after the law

was enacted in Mexico City. Both of them argued that the ILE was violating ten articles of the Mexican Constitution.⁹⁴

The arguments for and against the policy are based on ideologies with different underlying values and beliefs. In the case of the CNDH, the Commissioner's beliefs determined the attempt to block the policy. He did not discuss the issue with the Commission's Advisory Council and still submitted the claim on behalf of the Commission.⁹⁵ The majority of Councillors did not agree with putting the claim forward, and were actually in favour of decriminalising voluntary abortion. During one of the six public audiences held in the Supreme Court of Justice to argue in favour or against the Mexico City law, Juliana González, member of the CNDH's Advisory Council, made a statement where she explained her position and that of four other Councillors in favour of the constitutionality of the law under debate.⁹⁶

The unconstitutionality claim put forward by the Human Rights Commissioner is built upon the understanding that the National Constitution protects the right to life since the moment of conception. The statement made suggested that Mexican laws protect human life from conception and that Article 4 of the Constitution was misunderstood by the Mexico City legislative. The Commissioner believes that the product of conception is a bearer of human rights, as is a child or adult. He states: "Human rights, including those of the product of conception, must be protected by general rule. Not doing so violates fundamental principles and values on the tutelage, warranty and respect for human rights" (Suprema Corte de Justicia de la Nación 2009). In other statements, he also makes clear his beliefs about human life:

What the constitution protects is the essential human life nucleus, that is, the group of cells without which a human being cannot exist. This essential nucleus of human life, in the case of the conception product is the embryo, without these cells as few as they are, life in human form cannot exist... (Soberanes 2008)

In his unconstitutionality claim, the Commissioner argues that Mexico had signed international conventions on human rights, which include the right to life. Therefore, Mexico City's law violates these agreements:

⁹⁴ 1°, 4°, 6°, 14, 16, 22, 24, 73, 123 and 133. Suprema Corte De Justicia De La Nación, 'Sentencia de la Acción de Inconstitucionalidad 146/2007 y su acumulada 147/2007', (México, DF: SCJN, 2009).

⁹⁵ Interview with member of CDHDF Advisory Council, 11/04/2008

⁹⁶ Sesiones del Pleno. Suprema Corte de Justicia de la Nación. http://informa-scjn.webcom.com.mx/sesiones_del_pleno.html accessed 09/02/2010

Right to life before birth and since conception is recognised by international conventions like the Convention on the Rights of the Child, the International Covenant on Civil and Political Rights, and the American Convention on Human Rights. (Suprema Corte de Justicia de la Nación 2009)

A central issue in the debate is the right to life of the product of conception and women's right to choose over their motherhood. Soberanes argues that the "right to life is a fundamental right that does not confronts a woman's right to responsible motherhood and reproductive rights" (Soberanes 2008). The document presented to the Supreme Court states that "the right to life cannot be diminished by the right to choice" (Suprema Corte de Justicia de la Nación 2009). For Soberanes, there is no conflict between rights, but clearly the right to life comes first and before women's rights:

The fact that a child is inside her womb does not give the woman the right to dispose of it, since it is not about her body, but a human being genetically distinct from it. The existence of a different DNA makes us conclude that they are two distinct beings, hence one may not legitimately dispose of the other. (Suprema Corte de Justicia de la Nación 2009)

The Attorney General's claim of unconstitutionality is based on the same beliefs as those of Soberanes: the product of conception is a person and hence a bearer of rights. The right to life of the product of conception thus comes first, and over and above women's rights. I quote Attorney General Eduardo Medina-Mora's statement to the Supreme Court in one of the public audiences held by the Court: "It is evident that the product of conception is a person and therefore is inadmissible that its life can be taken away until the twelve week of pregnancy just because of the mother's consent" (Medina-Mora Icaza 2008).

The Attorney General's claim document presented to the Supreme Court of Justice affirms that:

The state has the responsibility to directly protect the right to life from the moment of conception itself, and to promote the value and respect of human life and of the rights that derive from its sole existence...
(Suprema Corte de Justicia de la Nación 2009)

Medina-Mora also refers to international conventions on human rights that Mexico has signed. According to him, the International Covenant on Civil and Political Rights

on statement 6.1 reads that the right to life is inherent to a human person and this right is protected by law. The Convention on the Rights of the Child foreword states that a child needs protection and special care, even legal protection before and after birth. Finally, the American Convention on Human Rights in Article 4 states that every person has the right to life and that this right is protected by the law since conception.

Other arguments for the unconstitutionality of abortion policy are that the Mexico City Assembly of Representatives legislated on matters outside of their mandate, which extends only to the local level. It legislated on matters that are reserved for the Union Congress only, like the General Law of Health which is above all local laws. The CNDH also used this argument in its claim. Both unconstitutionality claims affirm that the Mexico City reform was inexact and unclear in judicial terms.

Some of the arguments against the ILE, as explained above, are verifiable, while others are not. Judicial terms and clarity of the law are subject to examination by judges and experts. The same applies to Mexico's adherence to International Conventions. Supporters of the policy pointed out that, when Mexico signed the afore-mentioned International Conventions, a reservation on matters about the right to life *since conception* was placed, therefore not subscribing to that particular issue (Suprema Corte de Justicia de la Nación 2009). The legal coherence and adherence to the Federal Constitution, as well as the clarity of the law, are the sole responsibility of the Supreme Court of Justice. However, the argument about the right to life over and above the rights of women is based on different interpretations. These interpretations come from different values and beliefs that are difficult to prove right or wrong. They denote moral stands that deal with beliefs about what is good and bad. If the underlying morals or ideas are not shared, there is an inevitable conflict of values and beliefs. Table 5.2 shows a summary of the conflicting ideas of the federal level authorities and the Mexico City government.

The supporting ideas of the unconstitutionality claims are built on Christian beliefs: life begins at the moment of conception and any attempt to put an end to a human life is a major sin. In addition, the ties of the ruling party at the federal level with the Catholic Church explain this opposition to decriminalise abortion in Mexico City. The conservative party, PAN, holds power at the federal level with President Felipe Calderón. PAN has its origins with groups of liberals in favour of capitalism and private property, and Catholic militants (Laborde 1988; Reveles Vázquez 1998).

The party's manifesto reflects Christian values such as the common good and the right to life. Soberanes, appointed as head of the CNDH from 1999 to 2009 (two 5-year terms) is a devoted Catholic and member of the Opus Dei – a very conservative branch within the Catholic Church.

Table 5.2 Summary of opposing ideas between local and federal levels regarding decriminalising abortion in 2007

Local level: ALDF/GDF/SSDF	Federal level: CNDH/PGR
Right to life is a fundamental right. Other rights like the right to freedom, dignity, education, health, are fundamental but are not prioritised or hierarchical.	The Right to life is the essential assumption, base and condition of all other rights in the constitution.
The constitution does not specify that the product of conception has the right to life.	The state has the responsibility to protect the right to life from conception. The product of conception has the right to life.
Women's rights come first before the right of the product of conception to life.	One cannot put the right of a woman to choice above the right of a human being to life. A woman cannot dispose of the rights of another human being just because it is inside her body.
The state protects the right to life from birth.	From conception a human being is protected by law.
Women's rights to choice and reproductive life, self-determination over her own body.	Reproductive rights are for both men and women and not exclusive of the latter. Gender equality – the father should not be excluded from decisions during pregnancy. Right to fatherhood.
The product of conception at any time during pregnancy is not a person, hence not a holder of rights.	Discrimination against the product of conception, protection to life depends on time (12 weeks)
A person or human being is considered as such when it has the possibility to exist on its own.	A human being starts existing from conception.

Source: Elaborated by author based on official documents of the claims of unconstitutionality, the SCJN ruling document, and the statements presented in public audiences.

The Supreme Court of Justice decided to hold six public audiences in 2008 where the government, CSOs and individuals were able to speak in front of the High Ministers to expose their arguments either in favour or against the ILE law constitutionality. Civil society's participation in the debate was prominent, as I explain further in Chapter Seven.

The Supreme Court voted against the unconstitutionality of the Mexico City reform with eight votes against it and three in favour. They recognised the lack of consensus in both domestic and foreign legal works, as well as in international laws, on matters dealing with abortion. The Court's ruling document states that there is no common understanding of "ethical, moral, philosophical, scientific and legal criteria of when human life begins" (Suprema Corte de Justicia de la Nación 2009) and they found conflicting assertions on them. In the same documents, the Supreme Court Ministers stated that their role was to define whether the Mexico City law transgressed the Mexican Constitution only.

The Supreme Court's ruling came out in August 2008, more than a year after the policy was enacted in Mexico City. During unconstitutionality processes, the law in question may be applied and implemented as if it were constitutional. However, the fact that the legality of the ILE policy was in question hindered its implementation, especially by providers other than the Mexico City's public health care services. Once the ruling had passed, the legal way was paved for full implementation by different providers. Nonetheless, the policy still met with resistance.

Federal hospitals and social security institutions refused to implement the policy. They argued that since they were federal institutions they were required to follow the federal legislation only. As this was a local law, they said they were not even governed by it in their facilities in Mexico City.⁹⁷ This kind of conflict between federal and local legislations was unprecedented. The new abortion law is effective in Mexico City's territory, and hence all health care establishments should be subject to it. The president of the Commission for Mexico City in the Federal Congress, also supported by PRD legislators, sent a letter to the National Directors of both IMSS and ISSSTE requesting the implementation of the ILE policy in their facilities in Mexico City. He argued that the Federal Social Security laws were not an impediment to providing abortion services in Mexico City (Llanos et al. 2007). Also, a prominent doctor of law, Dr Carrancá y Rivas, made a public statement and said that these institutions, together with the federal hospitals managed by the Ministry of Health, were obliged to implement the policy since they were not entitled to extraterritoriality from this law, and were actually denying a right to women (Berumen 2008).

⁹⁷ IMSS communiqué to their employees – interview with two IMSS officials, 07/05/2008

The ILE policy designates only public health care institutions managed by the Department of Health to provide abortion services:

Public health care institutions under the Mexico City government must provide, free of charge and under quality conditions, termination of pregnancy procedures as established by the New Penal Code for Mexico City, when an interested woman requests it. (Gaceta Oficial del Distrito Federal 2007)

But other providers can offer these services too, because abortion is no longer a crime in the Mexico City Penal Code.

The first attempt to bring down the ILE policy and stop its implementation came with the two claims of unconstitutionality put forward by federal level authorities. Conflicting ideas and beliefs on abortion and sexual and reproductive rights, that is the policy issue in this case, put the implementation of the Mexico City policy at risk. These beliefs are based on opposing Pro-life and Pro-choice ideas, as explained in Chapter Four. Pro-life values and beliefs are heavily influenced by the Catholic Church, while Pro-choice ideas are mainly influenced by feminism.

Although the unconstitutionality claims were unsuccessful, the clash between the federal and local authorities is still there. ILE policy services have not been extended to federal hospitals and social security institutions. Even though these health care institutions could offer the service lawfully, there is a lack of political will to carry it out. This clash has constrained the implementation of the Mexico City policy by not extending access to services.

Actors' ideas, values and actions greatly influence the implementation processes. Different ideas, values and beliefs of individuals at the federal and local authorities have constrained the implementation of both PHI and ILE policies at the operationalisation level. The clash between federal and local governments thus determined to a great degree the way each policy was put into practice. These cases show that key individuals are central in influencing implementation. Dr Laurell's position towards the PHI was not the position of her political party, just as Soberanes' beliefs about the ILE policy were not shared by the Counsellors of the CNDH that he presided over. These individuals acted according to their ideas and beliefs, constraining the effective implementation of the corresponding health policies. The membership of key individuals in advocacy coalitions and networks, as explained in Chapter Four, explains their behaviour and actions towards certain policies. Advocacy

coalitions are held together by a shared system of beliefs and members act accordingly.

In the case of private and third-sector health care providers, it is also actors in decision-making positions that determine whether to participate in service delivery or not. The next section explains the constraints found in these nongovernmental sectors to implement the services of the two case study policies in Mexico City.

5.3 Private and non-profit sectors' participation

The participation of private and third-sector health care providers in public service delivery enhances effective policy implementation. Access to services is extended when the number of health care facilities offering the service increases. Further, the participation of private and third sectors offers a wider choice of providers to service users. Research in Mexico City shows very limited participation of private and third sectors in the PHI programme. Decision makers at these institutions, such as hospital directors and heads of NGOs, base their decision to participate in public policy implementation primarily on their ideas, values and beliefs about the policy in question.

Findings for this section should be taken with some caution, as they are based on a small number of interviews and claims are more illustrative than conclusive. Private health care providers in Mexico City are more difficult to give an interview for research purposes. For illustrative purposes, I tried to include at least one of each type (for-profit according to size; non-profit according to ideology, that is, faith-based or secular). Nine interviews were carried out with individuals in private health care institutions and eight interviews with individuals in non-profit organisations. Private providers include establishments that exemplify their different characteristics: large and medium-size hospitals and small clinics. The third-sector interviewees also include different examples: faith-based (Catholic) and secular, offering and not offering voluntary abortion services. In this way, different kinds of providers are covered and serve as in-depth examples of these two sectors.

The private health care sector is very important in Mexico City. Official surveys and data do not differentiate third-sector from private provision, therefore the figures presented here include both sectors. Private health expenditure in Mexico for

2004 was 54 per cent⁹⁸ of the total health expenditure. Figures for 2006 show that 47.1 per cent of the population in need of ambulatory health services used private health care services in Mexico City. Only 12.9 per cent used local facilities of the Department of Health, which include PHI services.⁹⁹

The sector is very heterogeneous. Private health care units range from individual doctors' practices to large health conglomerates offering high-tech treatments. As Chapter Three explains, small-size clinics with only a small number of acute care beds are the predominant type of private health providers. According to official data for 2005, 28 per cent of the total number of doctors work in the private sector, together with 16 per cent of nurses. The system accounts for 30 per cent of acute care beds and 75 per cent of the total number of hospitals in the country. However, out of this number, only 6.2 per cent are hospitals with more than 25 acute care beds and 69 per cent have less than 10 beds (Secretaría de Salud 2007).

Private and third-sector providers interviewed were very poorly informed about the two case study policies. Little was known about the possibility of participating in the PHI as service deliverers when contracted by the government. This lack of knowledge is a sign of minimal interest in public policy. Furthermore, having neither interest nor information about these kinds of policies is a major obstacle to the uptake of public policies and public-private partnerships. Some interviewees confused the PHI with the local Free Health Care Programme or with other federal programmes. It was surprising to find that several gynaecologists interviewed were not familiar with the ILE policy after over a year since its approval. Some of them did not know that abortion had been decriminalised for the first twelve weeks. Others were not aware that private providers were also able to provide abortion services.

Private Health Care Providers

To participate in the PHI, providers must have a contract with the government. Through these contracts, governments would pay for the services delivered to PHI beneficiaries. However, in the case of the ILE, there is no need to have a contract with the government. Private providers may offer the service independently since it is now legal. Field research shows that private health care providers seem concerned about

⁹⁸ Sistema de Cuentas en Salud a Nivel Federal y Estatal (SICUENTAS), <http://sinais.salud.gob.mx/recursosfinancieros/index.html> accessed 25/07/2009

⁹⁹ Use of health services during the fifteen days prior to interview. ENSANut 2006.

three main aspects when deciding whether to participate in these policies: making a profit, maintaining their autonomy from the state, and having a good reputation and prestige in society.

Profitability, autonomy from the state, and good reputation and prestige are all expressions of values and beliefs. Following Inoguchi's (1998) definition, as presented in Chapter One, policy values are "a set of preferred beliefs and norms, principles and practices deemed important by individual citizens" (p.241). For individuals in charge of health care institutions within the market, profit-making is a core principle to observe. Autonomy, reputation and prestige are also based on principles. These providers care about the image they portray in society, that is, the perception that society – or social groups - have of them and their work.

The mechanisms to participate in the two case study policies are different for private health care institutions for the two policies. Nonetheless, the primary aspect that determines their participation in both policies is profit-making. As expected, profit-making is at the core of the private sector. It is the expression of the sector's main value: generating and accumulating wealth. However, a good reputation and prestige were also mentioned as important factors in most interviews with private health care providers.¹⁰⁰

Participation of the private sector in the PHI programme in Mexico City is very limited. As of 2010, five years after its commencement, there were no contracts between private health care providers and the local Department of Health for PHI services delivery. Private sector participation in this policy's implementation was only through the management of the supply of medicines.¹⁰¹

The reasons private health care interviewees gave as to whether or not they would participate in the PHI scheme were based on their values and beliefs. Most small-size providers were interested in participating in this service delivery if it were to result in higher revenue for them. They were also concerned about maintaining the quality of services in case of an increase in the number of service users. "With more patients coming, if the number surpass the capacity of the clinic, then the quality of our services would diminish."¹⁰² Only one large-size hospital interviewee considered

¹⁰⁰ Interviews with private hospital directors and doctors in private clinics, April-May 2008, and January 2009.

¹⁰¹ Interview with Mexico City PHI director, 12/03/2008, and updated in http://www.salud.df.gob.mx/ssdf/seguro_popular/ accessed January 2011.

¹⁰² Interview with private hospital director, 15/01/2009

participating in the PHI. For her, negotiating a profitable deal with the government was the main reason for taking up the programme.¹⁰³ Other interviewees, most of them from medium and larger hospitals, were not interested in collaborating with the government in the PHI implementation. They believed that a deal with the government would not be profitable.¹⁰⁴

In addition to profitability, respondents from medium and larger hospitals were also interested in maintaining their reputation and prestige. For example, three interviewees mentioned explicitly not being interested in “having poor people as clients”, as most PHI beneficiaries belong to the poorest two income levels in the country. This type of response shows the high value that these health care providers give to their reputation of having certain social classes as clients.

Another obstacle posed to private providers in participating in the PHI is the negative ideas that individuals have about the policy. To illustrate this, I quote one respondent who referred to PHI as a “political bluff... a joke, just another political programme...”¹⁰⁵ Respondents with negative ideas did not believe that the policy would improve access to health services for the poor, or that it would be effective at all. Also, several interviewees refused to collaborate with the government because they were concerned about keeping their autonomy rather than having to be subject to government guidelines and norms that would restrict their practice.¹⁰⁶ There is a widespread lack of confidence in the government. Most interviewees in management positions believed that civil servants are corrupt, inefficient and simply untrustworthy.¹⁰⁷

The lack of participation in service delivery by the private sector is not the same throughout the country. In other states, for example Tabasco, Baja California Sur, and Jalisco, there is participation of private health care providers.¹⁰⁸ By 2010, PHI officials in Mexico City had not yet approached private providers to negotiate a contract. According to them, the reason for this was because they were not in need of further provision, since the Health Department had a good coverage of services and

¹⁰³ Interview with hospital director, 22/05/2009

¹⁰⁴ Interviews with hospital directors, May 2008 and January 2009

¹⁰⁵ Interview with hospital director, 22/05/2008

¹⁰⁶ Interview with two hospital directors, 15/01/2009.

¹⁰⁷ Interviews with two private hospital directors, 22/05/2009 and 16/05/2009

¹⁰⁸ Comisión Nacional De Protección Social En Salud, 'Informe De Resultados 2009'.

enough health care facilities to treat PHI beneficiaries.¹⁰⁹ Given the responses in interviews, it is very unlikely that private providers would take the initiative to approach the government. In this case, both the government and private providers are simply not interested in collaboration.

The case of the ILE policy is different in the mechanism for private sector participation. Direct collaboration with the government is not necessary to take up the policy. Private health care providers have the choice to simply either offer the service or not. Actors' values and beliefs play a more evident role in this policy implementation. Having prestige and a good reputation are also very important factors. Research shows that big hospitals have taken a more careful approach towards voluntary abortion. They are not officially offering this service in order to maintain their prestige. Respondents from this type of provider believe that keeping a "good image" benefits their business, even though there is no evidence for it. Although this position does not permit doctors to perform voluntary abortions, hospitals are not strict in enforcing it. An interviewee mentioned that:

...each gynaecologist has his[her] own position... the hospital does not accept it [Termination of Pregnancy policy], but doctors neither tell me nor let me know... it's their own professional responsibility...¹¹⁰

This implies that abortions may be performed but not openly and without official recognition by hospital authorities. It was common before the decriminalisation of abortion, and it seems that it still is, for doctors to register the procedure as something else, like a colposcopy or a smear test, in order to keep secrecy over the practice of voluntary abortions. Therefore, it is very difficult to keep track of abortion practice in private hospitals even when it is legally permitted. These providers are more interested in maintaining their image than in what they really do. Other respondents that also expressed opposition to this policy, because of their wish to maintain a good reputation and prestige, said that they did not wish to be seen by society as an "abortion place". One respondent said "we are a decent establishment".¹¹¹

The above examples illustrate how ideas, values and beliefs held by individuals and society may constrain policy implementation by private providers. They are interested in complying with principles and norms shared with the social

¹⁰⁹ Interview with SSDF officials, April 2008

¹¹⁰ Interview with hospital director, 16/05/2009

¹¹¹ Interview with hospital director, 18/05/2009

groups they belong to. As observed in this case, private providers based their decision to take up a public policy upon their own values and beliefs. In a similar way, research found that third-sector providers also based their decision to participate on their values and beliefs, although the principles they follow are not the same as those of private providers.

Third Sector Participation

As with the private sector, NGOs are not required by law to carry out public policies unless they wish to do so. In the PHI policy, at the time of fieldwork, the third sector was not involved in service delivery. But in the case of ILE, at least two NGOs were providing abortion services. This section looks into the uptake of PHI and ILE policies by third-sector health care providers in Mexico City. It focuses on the reasons for participating, or not, when the opportunity arises. I look into what people in management positions think about actually providing abortion services - or not, as the case may be.

In contrast to market organisations, NGOs have a stronger ideology that guides their work. They are not concerned with profit-making, but with financial sustainability. Third-sector interviewees have a more positive view of the PHI compared to those of the market sector. Two NGO directors¹¹² mentioned that the policy was a good opportunity for them to expand health care services to those in need. Both NGOs operated nation-wide and in other states they were already collaborating with the government to provide PHI services. They perceived this experience as helpful and are keen to do the same in Mexico City. The two NGOs were working on a project to present to the local PHI authorities and negotiate an agreement. However, at the time of writing, a contract had not been settled yet. Nevertheless, the willingness and planning to implement the PHI is in itself relevant for this analysis.

The main reason these two NGOs have decided to participate in the PHI is their belief in the policy. NGOs are convinced of the programme's objectives and mechanisms to improve and increase access to health care to the population previously excluded from social security. Further, they welcome the idea of public-private collaboration in the delivery of health care services. These NGOs already

¹¹² Interviews with NGO directors 13/03/2008 and 16/05/2008

work in poorer and marginalised areas, so they see public financing as an opportunity to improve and extend their services. They are not dependent on public financing to operate, so access to resources is not the main reason to collaborate with the government. They believe in the policy and in public-private partnerships, which is an element that the policy supports.

In the case of the ILE, ideas, values and beliefs play a greater role than in the PHI policy. This was expected since this law deals with moral issues and may be categorised as a “morality policy”, as Chapter Two explained. Interviews show that the ideas and beliefs of providers constitute the most important factor in the NGO decision to implement the policy. Ideological stands on the issue of abortion tend to define the third sector. At least two NGOs with a firm pro-choice ethos, Marie Stopes and IPPF member, Mexfam, are offering voluntary abortions in Mexico City. Both of them provide reproductive health services and information. Marie Stopes actually began activities in Mexico City after the law was enacted, when they found a window of opportunity to extend their action there. In contrast, Mexfam has been around for more than 40 years and joined IPPF in 1983. They have been at the forefront in contraception methods and reproductive health promotion.

On the opposite side of the fence are Catholic NGOs like Caritas. This organisation has a health care delivery programme through clinics called CECAMPS in Mexico City. They serve poor and marginalised population groups. Obviously, Caritas, as the “lay arm” of the Catholic Church, rejects abortion and contraception. Although they offer gynaecological services in the CECAMPS, they focus on pregnancy care. A secular NGO¹¹³ interviewee expressed not having a particular position towards abortion and the ILE policy, but that they believed in doctors’ autonomy and freedom of practice. In this way, this NGO leaves the final decision to perform abortions to physicians. In all of these cases, participation in the ILE policy is determined by ideas, values, and beliefs of individuals.

The NGOs included in this study reflect the three positions an organisation can take towards a contentious health policy like the decriminalisation of abortion: in favour, against, or neutral. The pro-choice NGO uses the language of women’s reproductive rights, and the discourse of the right to choice permeates all levels, from management to front-line staff. Personnel working in this institution receive training

¹¹³ Interview with head of NGO 20/05/2008

and information about these themes and other human development topics. Similarly, the faith-based NGO has the Pro-life discourse spread throughout the organisation. However, the institution without an official position on the ILE policy does not discuss the issue and leaves the decision to the medical practitioner.

Increased resources and higher incomes through the provision of abortion services seem to be unimportant for NGOs. They work on a fee-for-service basis and also receive donations to support their activities. Marie Stopes charges only half of the price that smaller private clinics charge for abortion procedures. Mexfam lost some of its donors when directors decided to provide ILE policy services. However, this was not a deterrent for the organisation to carry on and implement the policy.

Ideas, values and beliefs seem to be the main factor that determines whether or not third-sector service providers participate in the ILE policy in Mexico City. NGOs are strongly driven by the values they hold. If the underlying policy beliefs in question are supported by the NGO, then it is likely that it will collaborate with the government or take up the policy. In contrast, private-sector providers at administrative positions prioritise profit-making over any policy beliefs they hold. They also seem to value enjoying a good reputation and prestige in society. Again, these are based on ideas, values and beliefs shared by social groups. Private providers would only participate in public policy implementation if it meant they could make profits, or enhance their reputation and prestige.

5.4 Conclusion

This chapter explained how factors related to service delivery arrangements influence the implementation of the PHI and the ILE policies in Mexico City. It focused on the operationalisation level of policy implementation. Major constraints for both policies under study stem from conflicting values and beliefs of individuals in key positions at federal and local level governments. It shows that, in decentralised service delivery arrangements, the relationships between the federal and the local authorities are very important.

The implementation of the PHI scheme was put off by Mexico City health authorities for more than a year. Potential beneficiaries were excluded from this policy's services until federal and local authorities managed to reach an agreement. With regards to the ILE policy implementation in Mexico City, this was threatened by

federal authorities. Based on their values and beliefs, the Attorney General and the National Ombudsman put forward unconstitutionality claims to the Supreme Court of Justice. Although the Court ruled in favour of the local policy, during the controversy its implementation was held back. Both cases show that the ideas, values and beliefs of individuals at federal and local levels are central in constraining or enabling policy implementation. The chapter compared the ideas that key actors have about the most relevant issues that the policies raise.

This chapter also shows that, in both case studies, the service delivery arrangements in place hindered policy implementation. Federal health care providers refused to offer voluntary abortion in Mexico City, thus restricting access to these services. For the PHI policy, agreements between local health authorities and federal hospitals were established after there was a change of administration. The head of the Health Department and higher managers were replaced by individuals with favourable attitudes towards the PHI. This change improved the relationships with federal health authorities. As a result, access to services was extended to some federal hospitals.

Access to services has been increased with the participation of private and third-sector providers in service delivery. Therefore, their involvement in policy implementation is considered as enhancing its effectiveness. This chapter addressed the degree of collaboration of private and NGO health care providers in both PHI and ILE policies. It found a very limited participation of these sectors in the delivery of voluntary abortion services. At the same time, there was a lack of collaboration by these sectors in the implementation of the PHI.

The reasons these types of organisations gave for participating or not vary according to their values. Private health care providers seem to be more concerned with profit-making, good reputation and prestige. Most of them would participate in the PHI only if it entailed a profitable contract. Bigger hospitals were not interested in providing services to the poor, as PHI beneficiaries, and attribute this to maintaining an image and prestige in society. They opposed the ILE law in discourse, although in practice doctors may perform abortions without reporting it to hospital authorities. This is also an example of the importance they give to reputation and prestige. Smaller, private clinics were less concerned with these issues and more interested in increasing profit.

Service delivery arrangements are relevant in policy implementation. However, it is the actors involved and their ideas, values and beliefs that determine

relationships between different levels of government and the service providers under their jurisdiction. Conflict of values and clash of ideas about policies constrain effective implementation.

The next chapter addresses the service delivery level of the implementation process. It focuses on street-level personnel and the kind of issues they face in day-to-day service delivery. The chapter responds to the questions regarding managerial practices and how they may influence staff behaviour to favour policy implementation.

6 Effective implementation: beliefs or managerial practices

This chapter addresses the issue of managerial practices within implementing agencies and their effectiveness in enhancing policy implementation. The chapter contrasts these with the values and beliefs of those in charge of implementation. The previous chapter analysed the operationalisation level of the implementation process. This chapter focuses on the service delivery level. This level is where services are actually provided to the population – where implementers meet face-to-face with policy beneficiaries. Hence, it deals with the attitudes and behaviour of “street-level” (Lipsky 1980) or front-line staff within implementing agencies.

Good management is often cited as one of the key factors for ensuring successful policy implementation in the NPM literature (Kaul 1997; McLaughlin et al. 2001). The aim of the chapter is to explain how managerial practices and individuals’ beliefs influence the effective implementation of policies in the case of Mexico City. It looks into practices such as performance monitoring, understanding of policy objectives and procedures, incentive mechanisms and training of staff, in order to understand how management affects the way policies are carried out on a day-to-day basis.

Managerial practices are contrasted with the ideas and beliefs that implementers have about the policies they are asked to carry out. The chapter argues that employees’ ideas and beliefs determine their attitudes and actions, therefore having a greater impact on effective implementation. Managerial practices in place are relevant, but not more than implementers’ ideas and beliefs. However, this may be the case only in contexts where managerial practices are weak, as was found in the Mexico City case studies. No performance monitoring or incentives mechanisms were found within implementing agencies. Performance monitoring involves on-going reviews with personnel where their performance is compared against predetermined standards and goals. Incentives act as rewards to encourage desired behaviour of staff. Good management also requires having clear objectives and procedures and these need to be well understood by staff. In Mexico City, there was poor understanding of

the policies amongst street-level personnel. Training ensures personnel are better prepared when delivering health care services. In both case studies observed, staff training improved policy implementation.

Ideas and beliefs are difficult to measure. As expected, medical staff had stronger views about the ILE policy than about the PHI policy. In order to observe ideas and beliefs, I looked for attitudes and opinions expressed in field interviews that translate into actions. In the ILE case, implementers' beliefs about abortion were observed in their attitudes towards patients and medical staff performing abortions. Conscientious objection granted to medical personnel allows those whose values and beliefs go against abortion to be exempted of performing the procedure. The degree of discretion that hospital directors enjoyed allowed their personal ideas to influence policy implementation. In the case of the PHI policy, the negative ideas and beliefs that implementers had about the policy hindered its implementation. However, it was observed that implementers changed their ideas after they were able to see some of its benefits. This can be explained by the structure of belief systems proposed by Young (1979) and the ACF (Sabatier and Weible 2007). As Chapter Two explains, ideas and beliefs closer to the core of the belief system are harder to change. But opinions and policy beliefs are easier to change as they move away from the core. The PHI case shows that, with evidence and information, staff may change their ideas about the policy in question. Positive ideas regarding a policy determine positive attitudes, therefore enabling a more effective policy implementation.

The chapter is divided into four sections. It starts by explaining the degree of effective implementation at the service delivery level. Effective implementation is observed in the same terms as in the previous chapter, namely access to services and capacity to provide them. The second section explains the managerial practices found in implementing agencies such as hospitals and health centres. The third section illustrates how the values and beliefs of individuals involved in service delivery influence effective implementation in the case of the ILE policy. It looks into conscientious objection, discretion and work environment. The fourth section turns to the PHI case. It addresses policy beliefs and how their feasibility to change may improve service delivery.

6.1 Effective implementation at service delivery level

This section explains the signs of (in)effective implementation observed in the two case studies related to the service delivery level. Implementation at this analytical level is observed in routine activities and day-to-day actions carried out to ensure access and capacity to provide services to beneficiaries. This analysis is useful to understand the influence of managerial practices, in contrast to ideas and beliefs, on effective implementation. Access to PHI services is observed through affiliation of beneficiaries and participating health care units. Capacity to provide services is explained through available resources (such as staff, facilities and equipment), supply of medicines, and certification of health care units. In the case of ILE policy, access is observed through the number of beneficiaries and providers ready to deliver services. In terms of capacity, effective implementation of this policy is observed through resources available (including human resources) and waiting lists.

Points of reference are determined in order to measure effective implementation through the indicators mentioned above. They need to be compared to a standard or benchmark so they can be valued as a sign of effective or ineffective implementation. For the PHI case, national averages, where applicable, are used as a reference to determine how well Mexico City is doing compared to other states. Effectiveness is determined in relative rather than absolute terms. The standard is set by the national average, therefore taking into account the contextual conditions of implementation. Other indicators are determined by implementers' perceived or reported change, that is, an increase or decrease of personnel and equipment, improvement of facilities, and increased or decreased participation of health care units. In the case of the ILE, since it is a local policy, data is not comparable to other states and national averages. Therefore, other reference points are used; for example, providers offering services compared to potential providers not participating in the policy, medical staff performing abortions relative to conscientious objecting practitioners, and number of abortion procedures carried out compared to other services provided (in this case, I used the annual average of births).

Affiliation procedures are very important in order to carry out the PHI policy and enhancing its implementation. It is the gateway by which to access its services. In order to become beneficiaries of the PHI policy, the target population voluntarily signs up (affiliates) to it. Beneficiaries then have to re-affiliate every year to stay in

the programme. The lower the percentage of target population affiliated, the lower the degree of access to the PHI services. In this respect, Mexico City scores very low, and it is behind the rest of federal states. By the end of 2010, only 59.4 per cent of the target population was affiliated to the programme, compared to 88.5 per cent of the national average. Six of the 32 federal entities in the country have actually achieved 100 per cent coverage. Mexico City has the lowest percentage of re-affiliation rate in the country, with 11.8 per cent in 2010 (the national average is 73.5 per cent).¹¹⁴

Participation of health care units is also very important to ensure access to services. At the same time, certification of these units is necessary to ensure quality service delivery, hence it also reflects providers capacity. According to the PHI operation rules, health care providers have to comply with a number of requirements to ensure quality and standard service delivery, thus health care units need to be certified in order to participate in the programme. As a result, the proportion of certified health care units out of the total available, as well as its variation in time, serve as indicators of effective policy implementation. In Mexico City, by the end of 2010, there were 105 accredited primary health centres out of a total of 213 (49.3 per cent). Participation of primary health centres increased very slowly during the first years of rolling out the programme: only 22 primary units were certified by the end of 2005, 33 by 2006 and 34 by 2007 (16.4 per cent). On the other hand, there was a huge increase in only two years, from 2008 to 2010, when the percentage of participating health centres reached almost 50 per cent. However, certification of second level health care units was more efficient. Already by 2008, all of the total 18 hospitals managed by the Department of Health were certified.¹¹⁵

In terms of capacity to provide services, the PHI programme has been more effective compared to the accessibility of its services. Participating health care providers in Mexico City have appropriate facilities and resources to provide PHI services. The improvement of facilities, equipment and the hiring of more medical staff have been possible due to financial resources coming from the programme's financial scheme. Public health care services' capacity has been strengthened as a result of the PHI policy. At the time of fieldwork (2008), at least six of the eighteen hospitals that the Health Department managed had made improvements in their

¹¹⁴ Comisión Nacional De Protección Social En Salud, 'Informe De Resultados 2010', (Mexico, DF: CNPSS, Secretaría de Salud, 2011).

¹¹⁵ Comisión Nacional De Protección Social En Salud, 'Informe De Resultados 2008', (México, DF: CNPSS, Secretaría de Salud, 2009).

facilities, such as adding new operating rooms or refurbishing existing buildings. At least eight had acquired new equipment and hired more medical staff.¹¹⁶

The percentage of patients that received all or most of the medicines prescribed to them is another indicator of capacity. In this regard, Mexico City is below the national average; hence, it is less efficient than other federal entities. In addition to that, both the national average and the Mexico City indicators have been decreasing through time. In 2008, 72 per cent of patients reported having their medication provided in Mexico City (78 per cent national average); in 2009, the figure went down to 69.4 per cent (75.1 nationally). In 2010, this percentage decreased even further to 53.8 locally and to 68.7 nationally.

Turning now to the case of the ILE policy, it is relevant to consider that health care providers managed by the Department of Health were very prompt to offer abortion services. Access to services was not delayed. They were already accepting the first patients after just a couple of days after the enactment by the local Assembly of Representatives of the new policy. The number of procedures carried out and the number of health care providers involved are the main indicators of effective implementation in terms of access to services. The policy was enacted at the end of April 2007 and, by the end of the same year, there were 4,799 completed procedures carried out in 14 of the 18 public hospitals managed by the City's Health Department. By mid-March 2011, the total number of cases since enactment had reached 55,715.¹¹⁷ However, without a point of reference, these numbers mean nothing. Therefore, the annual average of abortions is compared to the annual average of births carried out in local health care units. Abortion procedures accounted for roughly 22 per cent of births carried out in public health care facilities for the same years (2007-2010).¹¹⁸

Implementation of this policy seems more effective in terms of access to services than in the capacity to provide those services. The observed indicators are existing waiting lists and resources available – including human resources, which is the number of medical practitioners that are in charge of performing abortions compared to the total. Fieldwork revealed that at least four of the public hospitals had long waiting lists of up to two or three weeks. This is not considered acceptable

¹¹⁶ Interviews with hospital directors. January-May 2008, and January 2009

¹¹⁷ GIRE, Grupo de Información en Reproducción Elegida, <http://www.gire.org.mx/contenido.php?informacion=222>, accessed April 2011

¹¹⁸ Sistema Nacional de Información en Salud, <http://www.sinais.salud.gob.mx/nacimientos/index.html>; accessed April 2011

medically, because the number of weeks of pregnancy is crucial in determining the procedure and eligibility for the procedure. The law states a maximum wait of five days from the time of requesting the service. However, the shortage of doctors performing abortions made meeting this condition impossible in many cases. Amongst other factors discussed later, the provision of “conscientious objection” in the ILE limits the number of doctors available to perform abortions. By January 2009, only 21 doctors were performing all of the abortion procedures carried out in public hospitals managed by the Health Department (Madrazo 2009). This number is roughly 9 per cent of the total gynaecologists working in these hospitals. In addition to reduced human resources available, some hospitals did not have the appropriate equipment either.¹¹⁹ In the very beginning, in April 2007, there were 16 public hospitals providing abortion services. By January 2009, the number was down to 11. The lack of sufficient facilities to operate the programme and insufficient number of doctors agreeing to perform abortions led some hospitals to drop out.

The PHI and the ILE policies differed in their effectiveness in implementation. In terms of access to services, the PHI policy lagged behind the other policy. The ILE policy was more effective in reaching beneficiaries, whereas the PHI had a low percentage of target population covered. The number of participating and certified health care units had increased only in later years, yet almost half of primary health centres were still not certified to serve beneficiaries by 2010. On the other hand, the PHI policy was more effective in terms of capacity to provide services. Health care units were improving their facilities, acquiring new equipment and hiring more staff in order to deliver better services. The aspect where the PHI was still deficient is the supply of medicines to patients. In contrast, the ILE policy did not have adequate resources to deliver services, therefore having a great impact on the implementation of this policy. The limited number of physicians performing abortions resulted in long waiting lists. The number of providers offering services was reduced due to the lack of sufficient human and material resources. Other hospitals were not able to offer services because they simply did not have the necessary equipment or trained staff. The following section analyses managerial practices in place within implementing agencies in order to see how these may influence the situations described above.

¹¹⁹ Interviews with hospital directors, April-May 2008 and January 2009

6.2 Managerial practices within implementing agencies

This section looks into the managerial practices within those health care establishments that are in charge of service delivery. It focuses on public health care implementers. However, private and third sectors that provide policy services are also considered in the analysis. As explained before, managerial practices observed for the purposes of this analysis are performance monitoring, incentive mechanisms, staff understanding of policy objectives and procedures, and training of staff. It was found that, if present at all, these practices were unacceptably weak. Public health care institutions in Mexico City seem not yet influenced by the NPM trend that has dominated public administration in other countries like the UK.

A clear understanding of the policy, its aims and objectives, procedures and guidelines, is central to its implementation. It is the starting point of good management practices. Those in charge of carrying out the policy have to know well and understand policy objectives and procedures. However, little understanding of the two policies was observed amongst street-level staff interviewed. In both case-study policies, hospital directors and medical practitioners had a poor understanding of the procedures to put the policies into practice. Some public hospital directors mentioned when interviewed that, when operations began after the enactment of the ILE policy, they did not know how to proceed. As one interviewee said: “there was no implementation strategy from the Department of Health, so each hospital had to find their own way...”¹²⁰ Policy implementation guidelines and norms came only after five to six months.

In contrast, in the NGO that provided voluntary abortion services, having and communicating clear objectives and guidelines to all personnel enabled its implementation. Staff interviewed in this organisation mentioned that knowing and understanding the procedures beforehand had been very important for them. Meetings were organised so that everyone in the institution was informed about voluntary abortion and its institutional procedures months before the service was actually offered. This gave staff enough time to get familiar with the guidelines, receive necessary training and avoid possible misunderstandings and mistakes.

As the case described above illustrates, the training of staff is very important for improving policy implementation. It enhances the capacity to provide policy

¹²⁰ Interview with Hospital staff, May 2008

services by ensuring that there are medical practitioners with the relevant knowledge to serve patients. Most service providers (public, private and NGO) observed in this study had training programmes that aim to inform and update personnel about the policy. For the PHI policy, staff training facilitated a better understanding of the policy by hospital and health centre directors.¹²¹ In the case of the ILE policy, the training of personnel had different outcomes. Most hospital staff was against abortion, so they refused to participate in training sessions. When they did attend, it is reported that they were hostile to the people running the workshop and eventually left the room as a sign of protest.¹²² Nevertheless, those doctors that did perform abortions received training in different abortion techniques and other issues related to their work. These trainings were necessary because medical personnel lacked the relevant knowledge and skills in induced abortion procedures, such as manual vacuum aspiration and the use of medicines.

Public health care providers eventually laid down norms and guidelines (rules of operation) for both policies; however, they did not set any performance targets or monitoring. They did not put in place incentive mechanisms in order to encourage desired behaviour. These managerial practices, together with a good understanding of norms and procedures, could contribute to a more effective policy implementation. Yet, it is not possible to attribute any of the signs of implementation effectiveness described above to absent or weak managerial practices.

The absence of stronger managerial practices in public health care institutions restricts any conclusion about the extent of their influence in effective policy implementation. It is impossible to illustrate how managerial practices may affect the implementation process if they are not found within implementing agencies. Deeper research on these specific issues is necessary to establish the influence of better managerial practices on policy implementation. This analysis, nonetheless, suggests that policy implementation may improve if those in charge of service delivery have deeper knowledge of the policy objectives, norms and guidelines before implementation starts. This can give some time for implementers to understand their role and responsibilities. Also, training of staff is essential to ensure capacity to provide the required health services.

¹²¹ Interview with PHI director 12/03/2008, interviews with public hospital directors, April-May/2008 and January/2009

¹²² Interviews with SSDF officials, April-May/2008 and January/2009

In the case of Mexico City, what seem to matter the most are the values and beliefs of those in charge of providing health care services. The ideas they have about the PHI and the ILE policies are decisive in terms of their attitudes and actions. The following section looks into the ideas, values and beliefs of implementers and the way they may affect policy implementation.

6.3 Implementers' values and beliefs – the termination of pregnancy policy (ILE)

Personal values and beliefs determine one's attitudes and behaviour. That is why, understanding the belief systems of those in charge of policy implementation and service delivery is important. Implementers' actions and inactions have a great impact on the effectiveness of implementation. This is well illustrated by the case of the ILE policy, which raises moral and ethical issues, hence addressing personal beliefs at the core.

The generalised opinion about the policy among objecting doctors interviewed is that it went against their religious beliefs, morals or against the Hippocratic Oath because “it is the termination of a life”. Other reasons mentioned for not participating were because they feared legal problems and because they did not want to “contribute to promiscuity and irresponsibility”.¹²³ In contrast, doctors performing abortions expressed being in favour of patients' and doctors' autonomy and freedom to choose what is best for them. They respected the patient's beliefs and saw it as part of their job to provide the service the patient requested.

This section looks into the ideas, values and beliefs that implementers have about the issues addressed by this policy. Three main areas are identified where the impact of those beliefs is greater: the right to conscientious objection, discretion of hospital authorities, and work environment.

Conscientious objection

The limited number of doctors willing to perform abortions was one of the most relevant obstacles to delivering policy services to the population. This resulted in long waiting lists and a limited number of hospitals being able to provide abortion services. It had a direct impact on both access and capacity to deliver services. The ILE policy

¹²³ Interviews with NGOs medical personnel, 09/04/2008

allows for conscientious objection so that doctors whose beliefs go against abortion are exempted from performing abortions. Conscientious objection in medicine has been traditionally accepted in many countries that support religious freedom. But in Mexico, it has come to the public attention only with the decriminalisation of abortion in 2007. Mexico City health authorities did not expect to have so many “objectors”. Public health care services were not able to cope with the demand and had long waiting lists going as far as three weeks. The law states that the procedure has to be performed no later than five days after the woman requested it, but these hospitals were unable to comply with this rule because they did not have enough doctors. Fieldwork revealed a high number of medical professionals that refused to perform abortions in public health care facilities. They appealed to their right to conscientious objection provided by the law. This means that medical staff, in public hospitals and health centres, are exempted from performing abortions if this practice goes against their “religious beliefs or personal convictions”.¹²⁴ In consequence, there are not enough doctors to fulfil the demand for services.

Values and beliefs are the core of conscientious objection. Objecting doctors referred to their religious beliefs (Catholic) or to the Hippocratic Oath taken at the end of their studies. They said that their job is about saving lives and not to stop a life inside the womb.¹²⁵ There were only 21 doctors actually performing abortions across the whole public health care services in Mexico City by January 2010 (Llanos 2010) and the Department of Health had to hire new medical staff. However, it was difficult to find qualified doctors willing to perform abortions. Moreover, the number of non-objecting doctors had decreased with time. In April 2008, the Health Department reported that 40 doctors were participating in the ILE programme, but by the end of July of the same year the number had gone down to 34 (Cabrera 2008). The most recent report available (January 2010) states that only 21 doctors were performing abortions (Llanos 2010). Nurses, social workers, other medical personnel and even administrative staff also refused to serve patients, even though the law only provides rights to conscientious objection to doctors directly participating in the procedure.¹²⁶

The implementation of this policy was also constrained by the limited number of hospitals providing the service. At the very start of the ILE, in April 2007, 16

¹²⁴ Ley de Salud del Distrito Federal, Art. 59. Gaceta Oficial del Distrito Federal, 17 September 2009

¹²⁵ Interviews with medical staff, April-May/2008 and January/2009.

¹²⁶ Interviews with SSDF staff, April-May/2008.

public hospitals were providing voluntary abortion services. By January 2009, however, the number of hospitals was down to 11. The reasons for this decrease are basically two: the lack of sufficient facilities to operate, and insufficient number of doctors agreeing to perform abortions. Mexico City health authorities realised that some general hospitals did not have a large enough gynaecology section to be able to receive abortion patients. This is the case for the Rubén Leñero Hospital, which was out of the programme almost from the beginning.¹²⁷ Others, like Hospital La Villa, Hospital Gregorio Salas and Hospital Balbuena, are not providing abortion services because all of their gynaecologists invoked conscientious objection.¹²⁸ Balbuena and Gregorio Salas Hospitals were providing the service until February and May 2008, respectively. An unfortunate event led to the suspension of this service in Balbuena. A 15-year-old girl died in hospital after having a voluntary abortion and the doctor in charge of the procedure was suspended. Nobody else in that hospital wanted to be involved in abortions so the service was cancelled. Gregorio Salas Hospital was forced to cancel the ILE programme when the only doctor performing abortions was called to another hospital.¹²⁹

Discretionality

Hospital directors have a degree of discretion that allows them to facilitate or obstruct the implementation of certain policies. In the case of the ILE policy, their behaviour is greatly determined by their personal values and beliefs about voluntary abortion. Hospitals that have the facilities to provide these services are obliged to provide them, as stated by the law. Hospitals must find a non-objecting doctor to perform abortions. This puts hospital directors in a difficult position: they can object to directly participating in abortion procedures, but they cannot refuse to operate the policy in their hospital. However, the amount of discretion they have is enough to either obstruct or promote the implementation of the ILE policy. In one case, the hospital director was against abortion, as were all of the medical personnel. He managed to keep this hospital out of the programme from the very beginning. Other hospital

¹²⁷ Interview with SSDF official, 22/01/2009.

¹²⁸ Interviews with SSDF officials, April-May/2008 and January/2009.

¹²⁹ Interview with SSDF official, 21/05/2008.

directors referred to this hospital as an “objecting hospital”. Even though the law does not permit this, the hospital director had enough power to resist the policy.¹³⁰

There are more examples of how directors of hospitals can encourage or obstruct policy implementation according to their own values and beliefs. The director of a maternity hospital was against the ILE programme and, even though the hospital provided the service, the facilities and resources allocated to it were limited. For abortion patients, the director provided only one bed in the A&E section and a tiny room for both administrative and surgical procedures.¹³¹ Patients were asked to bring their ultrasound results to confirm the number of weeks of pregnancy, which they had to have done privately. The doctor in charge of these services mentioned that, at times, they had three patients sharing the same bed, and that the ultrasound machine had been broken for some time and was not being replaced.¹³² The case of Ticomán Hospital illustrates the opposite. If the director is in favour of the policy, then he/she may encourage its implementation. Here, the director was in favour of the ILE policy. He believed in women’s right to choose, sexual and reproductive rights and the obligation of the state to realise these. This hospital had seven doctors performing abortions, which represented between 60-65 per cent of the total number of doctors (the highest percentage of non-objecting doctors in public health care hospitals). It is also the hospital with the second highest number of abortion procedures carried out by January 2010.¹³³

Work environment

The ill behaviour of objecting personnel towards those involved in the ILE policy, and also patients, is another factor affecting the operation of the policy. Doctors performing abortions were subject to verbal aggression such as disparaging comments and insults. They had been called names like “Dr Evil” or “murderer”.¹³⁴ Other personnel obstructed the work of these doctors by not doing or delaying administrative procedures, so they were forced to also carry out administrative tasks like registering the patient. One of the consequences of this adverse work environment

¹³⁰ Interviews with SSDF officials and staff, April-May/2008 and January/2009.

¹³¹ Direct observation.

¹³² Interview with doctor 16/01/2009.

¹³³ Raúl Llanos, 'A La Frontera Han Recurrido Al Aborto Legal 34 Mil 660 Mujeres: Salud', *La Jornada*, 1 February 2010 2010, sec. Capital.; and Interview SSDF official, 26/05/2009

¹³⁴ Interviews with SSDF staff, April-May/2008 and January/2009.

is that even fewer medical personnel wanted to participate in the implementation of this policy. In one hospital, four gynaecologists were hired to perform abortions once the policy was introduced. Two of these soon left the job and one called for conscientious objection, leaving only one doctor available to perform abortion services.¹³⁵ In another hospital, all the doctors hired specifically for these services left their job soon afterwards because they could not bear the tension and aggression. At the time of fieldwork, only one doctor was available in that hospital for all abortion procedures requested.¹³⁶

If the values and beliefs of individuals involved in policy implementation are not taken into account, their performance may suffer. Medical and social work personnel involved in the ILE policy, but whose values go against abortion, had a difficult time dealing with their job and their conscience. Some interviewees in this case mentioned being “worn out” and “very tired” of their jobs, but they did not want to leave and face the difficulty of finding work in times of high unemployment. A doctor stated with regard to her job: “It is hell”. This doctor did not tell her family about what she did at work because she felt embarrassed and guilty about it. She asked hospital authorities for a change of activities, but her request was denied. She did not invoke conscientious objection because, due to her contractual conditions, the hospital could dismiss her at any time. She thought that they would dismiss her if she refused to perform abortions, so she stayed. The way staff in this situation coped with their job was by trying to separate work from personal beliefs: “morally I don’t agree, but it’s my job”.¹³⁷ The head of social work in a hospital had to deal with distressed social workers because of their involvement with abortion patients. She related: “I tell them to take it only as their job and not like something personal, that way they are not responsible for what’s done...”¹³⁸

Health care practitioners in the afore-mentioned situation cannot perform well in their jobs. This, in turn, hinders service delivery. Abortion patients had complained to the Mexico City Human Rights Commission of ill treatment and refusal to provide services at some public health care hospitals. The Commission issued a

¹³⁵ Interviews with SSDF staff, April-May/2008 and January/2009.

¹³⁶ Interviews with SSDF staff, April-May/2008 and January/2009.

¹³⁷ Interviews with SSDF staff, April-May/2008 and January/2009.

¹³⁸ Interviews with SSDF staff, April-May/2008 and January/2009.

recommendation to the Department of Health¹³⁹ to improve service delivery. Some interviewees mentioned that ILE patients were very demanding and, at times, aggressive. As one doctor put it, “they are very difficult”.¹⁴⁰

The Department of Health had taken very little action to correct these problems. One that seems to be successful is the separation of facilities to provide abortions. The best example is the Beatriz Velazco Health Centre, where all the policy procedures including administration are located in a separate area within the centre. This area even has its own entrance, therefore abortion patients are not in contact with any objecting staff. After this separation, conflict amongst personnel decreased and patients reportedly felt more comfortable: they did not have to be sitting next to a woman waiting to deliver her baby. Conflict among staff also diminished in Xochimilco Hospital after personnel involved in the ILE policy were moved to a separate area.¹⁴¹ Despite these efforts, there is no emotional or psychological support to staff involved in abortion procedures. This is important, especially for those whose beliefs are against abortion but who still have to be involved in its practice.¹⁴² They do not object because they fear losing their jobs.

In contrast, the NGO that provides voluntary abortion services identified the need among their staff to have some kind of moral or emotional support, even though people working there are in tune with women’s right to choose and reproductive rights. Paying attention to the concerns and emotional state of its staff has enabled Mexfam to deal with conscientious issues and improve service delivery. In addition to human development workshops, they run an “emotional contention” programme that provides psychological support to social workers and doctors directly performing abortions.¹⁴³

This section explained how personal values and the beliefs of implementers affect the implementation process of the ILE law in Mexico City. This is becoming most evident in aspects such as the work environment, discretion of hospital authorities and the right to conscientious objection. One of the most relevant obstacles

¹³⁹ CDHDF Recomendación 15/2008 in <http://www.cdhdf.org.mx/index.php?id=reco1508> accessed 02/2010

¹⁴⁰ Interviews with SSDF staff, April-May/2008 and January/2009.

¹⁴¹ Interviews with SSDF staff, April-May/2008 and January/2009.

¹⁴² There are no data available about the number of doctors in this situation. I interviewed one doctor and one social worker who expressed these feelings during interviews.

¹⁴³ Interview with NGO director, May 2008.

in carrying out the ILE policy is the small number of doctors willing to perform abortions. The main reason for this lies with the personal values and beliefs that individuals have regarding abortion. An adverse and hostile work environment discourages medical staff from getting involved in service delivery. Hospital directors may enable or constrain policy implementation by controlling the resources available to it. The discretion they enjoy allows them to put into practice their own ideas and values. Finally, the right to conscientious objection allows medical staff to refuse to participate in activities that go against their personal beliefs. Although this right reduces the number of participating doctors, it must exist. It is neither advisable nor fair to oblige people to carry out activities that they perceive as a wrong-doing. The Mexico City case revealed that some doctors chose not to object to abortions because they were afraid of being dismissed. There thus needs to be support and understanding in such cases, if the ill-treatment of patients is to be avoided and service delivery improved.

6.4 Policy beliefs: accepting or refusing implementation – the Popular Health Insurance policy

This section looks into the ideas and beliefs that people involved in carrying a programme out have about that policy. It focuses on the PHI policy. According to the ACF, explained in chapter two, policy beliefs refer to the ideas and beliefs about a specific policy: “the way an individual believes a problem should be solved” (Sabatier and Weible 2007). Implementers are not “policy indifferent”, but rather have “relatively complex belief systems incorporating multiple values and perceptions of problem severity, causes, and impacts” (Sabatier and Zafonte 1997, p.5). Here, I analyse those ideas and beliefs about the PHI programme to show how they influence policy implementation. This case illustrates how people may change their attitudes if given relevant information and evidence, thus enabling a more effective implementation.

Policy beliefs derive from a person’s belief system, which is hierarchically organised. Chapter Two discussed different approaches to understanding systems of beliefs. It discussed Young’s (1979) and the ACF’s models of beliefs systems and how they complement each other. Both frameworks are organised in a three-tier organisational structure that takes into account the feasibility to change. At the centre

are deep core beliefs that are hard to change. These include normative and ontological assumptions, and fundamental values like justice, freedom and equality. The next level comprises policy core beliefs (“attitudes” in Young’s structure) that refer to applications of deep core beliefs and fundamental policy choices, such as the relative authority of governments and markets, and the causes of policy problems. The third level includes secondary beliefs (“opinions” for Young) that translate to policy preferences related to specific instruments or proposals (Sabatier and Weible 2007, p.195).

Understanding the structure of belief systems is useful for anticipating the potential value conflicts that constrain policy implementation. It is also important in order to address different beliefs and values and reach agreement within implementing agencies. The PHI case illustrates how changing opinions about the policy can improve its implementation. Table 6.1 sketches the main values and beliefs that underlie the two case study policies.

Table 6.1 Structure of beliefs supported by the Popular Health Insurance and the termination of pregnancy policies

Structure of beliefs	PHI	ILE
Deep core beliefs (ideology)	Right to protection of health	Right to decide over own body
Policy core beliefs (attitudes)	Health care as an individual entitlement	Women’s right to safe abortion
Secondary beliefs (opinions)	Voluntary insurance scheme	Public provision of abortion services

Source: Elaborated by author

Individuals involved in carrying out these policies may or may not share those ideas. It is important to understand the perceptions of individuals in strategic positions as front-line staff, regarding the policies they have to execute. The position of people regarding abortion is based on deep core beliefs that are hard to change. Value conflict is, therefore, more likely to occur and agreement will be more difficult to reach. In contrast to this, dissenting perceptions about the PHI are based on policy core or secondary beliefs. There was no disagreement on a person’s right to health protection; disagreement arose around the way this ideal could be achieved. Policy choices and opinions are easier to change, and so behaviour may also change to favour policy implementation.

Negative perceptions about the PHI policy made it difficult to promote its implementation. The Mexico City coordinator for the PHI policy stated that it was very difficult to get primary health care units on board. She reported that they were not interested in the policy because, in their view, the local Free Health Care programme was better suited to address the problem of access to health care.¹⁴⁴ The Free Health Care programme had been operating for six years when the PHI programme was introduced. At the start of the programme, dedicated personnel had to be hired in order to promote programme affiliation because staff in health centres refused to collaborate.¹⁴⁵ All of the nine front-line staff¹⁴⁶ (those in contact with beneficiaries) and the majority of hospital directors¹⁴⁷ (six out of eight) interviewed were critical of the PHI programme. They believed that the policy is not going to achieve its objectives, and that the package of services is incomplete and does not respond to the population's needs. Some interviewees saw it as a "fraud" and as an instrument to limit health care coverage. Others perceived the PHI to be a path to the privatisation of health care, a "neoliberal policy" and "not a real solution for the problem of access to health care". All interviewees at service delivery level, including front-line staff and directors, rejected the idea of having to go through yet another certifying or accreditation process as required by the PHI policy.

Attitudes and opinions about the PHI started to change when staff saw its benefits in tangible ways: more equipment, refurbishment of facilities, and more human resources.¹⁴⁸ Also, training and policy buy-in have contributed to changing policy perceptions among implementers. The PHI coordinator in Mexico City saw it as convenient to have a series of training workshops with the aim of further explaining the mechanisms and advantages of the programme to health care providers.¹⁴⁹ In addition, hospital directors were very pleased with the resource flow they experienced. One hospital increased its human resources from ten doctors to 27. Another one was able to hire 67 new members of staff, while a general hospital

¹⁴⁴ Interview with PHI director, 12/03/2008; interviews with SSDF staff, April-May/2008 and January/2009

¹⁴⁵ Interview with PHI director, 12/03/2008

¹⁴⁶ Interviews with SSDF staff, April-May/2008 and January/2009

¹⁴⁷ Interviews with SSDF staff, April-May/2008 and January/2009

¹⁴⁸ Interviews with SSDF staff, April-May/2008 and January/2009

¹⁴⁹ Interviews with SSDF staff, April-May/2008 and January/2009

received eight X-ray and three ultrasound machines, and one surgical C-arm.¹⁵⁰ By changing personnel's attitudes and beliefs about the PHI in Mexico City, the policy has gained momentum. From 2008 to 2010, there was a considerable increase in the number of primary health care facilities that were accredited to treat policy beneficiaries. Primary health centres were reluctant to participate but, with time, they became more open to it. Between 2008 and 2010, the percentage of certified health centres rose from 16 per cent to 49 per cent,¹⁵¹ suggesting that the implementation of the policy was improving.¹⁵²

In contrast to the PHI case, the ILE policy encountered tougher opposition. This is because, when action and behaviour are based on deep core beliefs, it is more difficult to compromise or change minds. Very little was achieved in trying to persuade objecting doctors to accept the ILE.¹⁵³ The decrease in the number of non-objecting doctors illustrates this. As explained in the previous section, adverse work environment was a key factor leading to this situation.

6.5 Conclusion

This chapter analysed managerial practices within implementing agencies, as well as the values and beliefs of individuals involved in service delivery. The purpose of this analysis was to understand how these factors influence the effectiveness of policy implementation with specific reference to the cases of the PHI and the ILE policies in Mexico City.

Effective implementation in terms of access and capacity shows very different experiences between the policies analysed. In the case of the PHI policy, more than half of the total number of primary health centres managed by the Department of Health was still not certified to treat policy beneficiaries, seriously affecting access to services. Also, the percentage of the population registered under the scheme in Mexico City is still low compared to other states. In the case of the ILE, capacity to provide services seems to be the major problem. There are only a small number of

¹⁵⁰ Interviews with SSDF staff, April-May/2008 and January/2009

¹⁵¹ Interview with PHI director, 12/03/2008

¹⁵² Interview with PHI director, 12/03/2008

¹⁵³ Interviews with SSDF staff, April-May/2008 and January/2009

medical practitioners willing to perform abortions that have not asked to conscientiously object.

Personal values and beliefs, as well as managerial practices (or the lack of them), may explain some of these inefficiencies. However, values and beliefs seem to better explain the outcomes of both policies in Mexico City. The managerial practices observed were weak and therefore not as relevant in routine policy implementation as actors' values and beliefs. It could be argued that, in contexts of weak managerial practices, values and beliefs of individuals gain relevance. However, this analysis is not sufficient to raise any conclusions on this matter. The perceptions that individuals in charge of day-to-day activities had regarding policy implementation determined their behaviour towards the policy. Because of their position at the front-line of service, policy support or disapproval may result in promoting or constraining its implementation. Nevertheless, the possibility to change minds and achieve policy buy-in can improve implementation processes. The likelihood of modifying ideas, values and beliefs, or compromising these, is better understood through placing those ideas into the structure of belief systems. It is important to identify policy beliefs and their underlying values. Values that are based on deep core beliefs are more difficult to change, as in the case of the ILE. But in the case of the PHI programme, dissenting ideas are based on opinions and are easier to change when relevant evidence is provided. Primary health centres accepted the PHI programme with time and later joined the programme. Hospital directors changed their negative perceptions after realising the benefits of the policy to the flow of resources.

Personal values and beliefs towards a policy have an impact on day-to-day activities. The ILE programme is a good example, where the discretion that hospital directors had in their jobs allowed their decisions to be influenced by personal values. There are examples where directors obstructed the implementation of the ILE law by allocating minimal resources to it. In other cases, a director in favour of voluntary abortion facilitated effective provision of abortion services. This policy also shows that different policy values can bring conflict among health care staff, resulting in an adverse and hostile work environment. All of the above have an impact on effective policy implementation.

The next chapter turns to the question of how citizens may influence implementation processes and therefore have better health care services. Implementers have to be accountable of their actions and behaviour. Accountability

mechanisms have to be available to citizens so that they can engage and participate in policy implementation.

7 Citizen engagement in policy implementation: from collaboration to accountability

Over the past two decades, mainstream organisations like the World Bank and the UN have promoted a greater engagement of citizens in public service provisioning (Fiszbein 2005; World Bank 2003). Citizen engagement means having an influence on the way services are organised and delivered to the population. It is argued that enhanced citizen involvement in service delivery “should result in stronger control over the actions of front-line providers and a corresponding positive change in the quality of services provided” (Fiszbein 2005).

Following the assumption that citizen engagement in this process may contribute to better services, this chapter looks into the mechanisms available to regular citizens in order for them to get involved in policy implementation or service delivery. The thesis aims to understand the factors that influence effective implementation and in what ways. Therefore, this chapter provides an analysis of citizen involvement in the implementation of the PHI and the ILE policies in Mexico City. It aims to find out to what extent this involvement influences service delivery in favour of beneficiaries. For the purpose of this study, citizen involvement or engagement refer to those actions that citizens carry out to voice their demands and needs in order to influence public policy. The ultimate purpose of these actions is improving service delivery, but also holding service providers to account. Examples of institutionalised citizen engagement in policy-making are participatory budgeting, public consultations, citizen councils and advisory boards. These mechanisms complement liberal democratic practices like voting. There are also informal or non-institutionalised channels of participation, such as public demonstrations. However, this study focuses only on the former in order to keep the attention on policy implementation processes.

The chapter argues that citizen engagement in the implementation process, as advisers, collaborators or accountability agents, improves service delivery. Spaces or channels available to regular citizens/service users to voice their demands and needs

constitute the formal mechanisms through which they can contribute to a more effective policy implementation. Also, citizens may organise themselves into CSOs to work towards common goals regarding policy and service delivery. Within the health sector and the policy areas under study, CSOs include medical professional associations, NGOs and think-tanks that work on issues like health systems, health care services, reproductive health and sexual rights, as well as NGOs that promote the right to life from conception. Civil society entails collective action, whereas citizen engagement may also take place on an individual basis. The analysis looks into both collective and individual actions that have the purpose of influencing policy.

The chapter starts with an overview of civil society in Mexico City and the existing spaces and mechanisms for citizen engagement. The second section analyses the channels and mechanisms available for citizen involvement in public policy. The third section examines the actual ways in which citizens engage in health policy and service delivery, especially in the case of the policies under study. It explains the role of advisory councils, the collaboration of NGOs with the Department of Health, and the accountability mechanisms that citizens use to file complaints about poor service delivery. The fourth and fifth sections look into the role of medical professional associations and medical schools, respectively, in order to achieve a deeper understanding of their influence on health policy implementation.

7.1 Civil society in Mexico City

This section sketches the contours of Mexican civil society. The purpose is to understand the context and development of the sector in order to analyse citizen engagement in policy-making. The Mexican literature on civil society emphasises the role of CSOs in the democratisation processes of the country. Leading scholars on the topic follow the works of Cohen and Arato, Melucci, Offe and Touraine. They tend to focus on the normative dimensions of the concept and its relevance to the Mexican context (Olvera Rivera 1999, 2003), the composition of social and political actors (Bolos 1999; Pliego Carrasco 2000) and the contribution of civil society to democracy (Álvarez Enriquez 2004). Issues on the participation of CSOs in the provision of public services are barely featured, while studies about citizen engagement in health policies are particularly limited.

Social movements and nongovernmental organisations

Civil society in Mexico is very diverse. In order to gain a clearer picture of its composition, I identify different types of collective actors according to how they are organised. Collective public actors may be categorised into four broad categories: social movements, NGOs, networks, and episodic coalitions. Social movements represent their own members or communities and mobilise to claim their own demands. Nongovernmental organisations are institutions with a degree of specialisation in a certain issue. They often employ professional staff and work for the benefit of others. This division between social movements and nongovernmental organisations is widely used in the Mexican literature to distinguish between popular movements fighting for their own rights, and institutionalised organisations working on issues that benefit social sectors or groups (Álvarez Enriquez 2004; Bolos 1999; Olvera Rivera 2003). Well-known NGOs in Mexico City, for example, work on issues such as housing, human and cultural rights, democracy and citizenship, and sexual and reproductive rights.

Social movements tend to be defined according to issues and locality or territory, for example, neighbourhood associations, labour unions, street vendors' and street workers' unions. These organisations may have clientelistic links with political parties; in the case of Mexico City, with the ruling left-wing party PRD or with the PRI (Hellman 1994). Social movements see political parties as an opportunity to have members appointed as government officials or as candidates for Congress representatives. Political parties, in turn, see social movements as a way of winning votes. They offer candidatures to social movement leaders according to the amount of people they can mobilise to support the party. The case of NGOs is different; they value political autonomy as it provides greater public trust. The link between political parties and NGOs is episodic and strategic rather than long term. Political parties and NGOs may approach each other during electoral times. For example, NGOs see it as an opportunity to advance their agendas to political parties in the hope that they can be translated into public policies if the party gets to power. Political parties, in turn, see NGOs as a resource to win legitimacy and public support (Álvarez Enriquez 2002; Olvera Rivera 2003).

NGOs and social movements often come together to form networks or coalitions in order to increase their influence (Bolos 1999). The difference between a network and a coalition is the degree of collaboration in time. Civil society networks

are established for joint action in longer periods of time than coalitions and usually by issue areas or sectors (Álvarez Enriquez 2004). They tend to have wider agendas than a specific goal. Coalitions act strategically at certain points in time or in episodes, such as electoral years. Their aim is to influence particular processes, for example, taking their agenda into political parties' manifestos. After the relevance for joint action passes, the episodic coalition dissolves.¹⁵⁴

Collaboration between CSOs and Mexico City's government was a trademark of the first elected government administration (1997-2000) (Álvarez Enriquez et al. 2002). The Civil Organisations Platform was created during this time in order to draft the social development law and the law to promote CSOs' activities.¹⁵⁵ *Coalición Hábitat México* is another successful example of public-private partnerships. Four urban and housing NGOs form this network and they work in partnership with the City government in a programme to improve housing conditions for the poor. The programme was conceived and designed by the network and is implemented together with the beneficiaries.¹⁵⁶

Changes in government administrations, even if they are from the same party, hinder the continuation of successful public policies. According to several activists, during the 2000-2006 administration in Mexico City, the links with CSOs were significantly weakened.¹⁵⁷ The available channels for civil society to participate in government policy processes define the way citizens may influence or change policies. The next section describes existing spaces that are used to promote citizen engagement in public policies.

7.2 Spaces for citizen engagement in Mexico City

The move from more traditional political citizen participation, from the ballot box to participatory spaces, entails the creation or development of new institutions and new types of relationships between citizens and the state. Gaventa and Valderrama (1999) explain that citizen participation "comes to mean more than taking up invitations to participate, extending to autonomous forms of action through which citizens create

¹⁵⁴ Original research by author (2005), unpublished.

¹⁵⁵ Interview with Canto Chac 10/01/2005; interview with Jusidman 15/02/2005.

¹⁵⁶ Interview with Ortiz 07/02/2005.

¹⁵⁷ Interviews carried out during January and May 2005.

their own opportunities and terms for engagement" (cited in Cornwall 2004). This section looks into the mechanisms available to citizens for making their voices heard and for holding service providers to account in the case of Mexico City's health care system.

The section builds on the New Democratic Spaces framework (Cornwall 2004; Gaventa and Cornwall 2001). These authors identify four approaches to citizen participation in public services. The first approach includes consultations with beneficiaries as service users or consumers. The second approach emphasises self-provisioning of services through CSOs. The third approach includes social movements that advocate for state provision of services. The fourth approach entails accountability mechanisms and new relationships between citizens and service providers (Gaventa and Cornwall 2001, p.iii).

Since 1997, the government of Mexico City has been elected by the population rather than appointed by the president of the country. The various governments of Mexico City since 1997 have shown different degrees of interest in promoting citizen involvement and have, in general, been open to collaborating with civil society. The first elected government in Mexico City enacted the Citizenship Participation Law (1998) setting a precedent for the rest of the country (Álvarez Enriquez et al. 2002). This innovative law established the mechanisms through which regular citizens could influence government decisions and actions. Citizen councils and neighbourhood committees became the two mediating bodies between the individual and government authorities. The law also provides tools for citizens to voice their policy preferences and demands: referendum, plebiscite, public consultation, public hearing, popular initiative, and neighbourhood assembly. Official representation of citizens is given through the neighbourhood committee. These committees are elected by universal vote based on "territorial units". Each unit has its own committee comprised of 9 to 15 individuals who work pro bono for a 3-year term. Territorial units are defined by electoral areas that vary in population size. The city has been divided into approximately 1,500 territorial units.¹⁵⁸

Initially, these New Democratic Spaces created in Mexico City brought about a high degree of optimism among civil society actors. However, these spaces have failed and have not provided a real voice to citizens (Zermeño et al. 2002).

¹⁵⁸ Ley de Participación Ciudadana del Distrito Federal, Gaceta Oficial del Distrito Federal, 27 de Mayo de 2010

Neighbourhood committees have not been renewed since they were first elected in 1999. Only two years afterwards, around 60 per cent of them were either not operating or were completely dissolved (Sánchez 2010). During the first ten years since the law's enactment, referendums and public consultations were organised only six times and mostly on the initiative of government officials. The Citizen Participation Law has been modified several times in order to correct deficiencies, but no reform has brought to life the democratic spaces it is supposed to encourage.

The use of the participation mechanisms provided by this law has been deficient and limited. Citizen participation specialists in Mexico City concur on the factors that contributed to its failure. They argue that neighbourhood committees were co-opted by political parties, therefore de-legitimising its mediatory role. Also, territorial units did not follow cultural or traditional geographical boundaries in which its inhabitants are used to associate, for example, to organise the local patron saint festivities and other popular/religious celebrations. Committee members are not paid for their time nor do they have a proper budget to operate, hence they found it difficult to work (Zermeño et al. 2002).

After the rejection of several initiatives put forward in the local Assembly of Representatives to re-activate neighbourhood committees, a deeper reform of the Citizen Participation Law took place in May 2010. The most relevant changes in this new bill were the establishment of committees based on neighbourhood and town boundaries instead of electoral areas, recognition of the need to be involved with political parties, a budget for committees to operate and the right to decide on how to spend one to three per cent of the total borough budget.¹⁵⁹ Prior to enacting the reform to the law, the Electoral Institute of Mexico City organised two consultative forums with CSOs and academics in order to include their proposals in the new bill. Several social and nongovernmental organisations participated in the forums. Elections for neighbourhood committees were planned to take place in October 2010,¹⁶⁰ eleven years after the first election.

Institutionalised spaces for citizen involvement do not provide the necessary power to effectively influence policy implementation. Some government agencies at

¹⁵⁹ Art. 83; Ley de Participación Ciudadana del Distrito Federal, Gaceta Oficial del Distrito Federal, 27 de Mayo de 2010.

¹⁶⁰ Instituto Electoral del Distrito Federal, Boletín de Prensa, 09 de agosto de 2010, http://www.iedf.org.mx/index.php?cadena=ut/ucs/boletines/COM2010/boletin_071.php accessed 17/08/2010.

both local and federal levels, such as the Women’s Institute of Mexico City and the National Council of Population, provide a space for civil society representatives. The purpose of these spaces is to listen to “society’s voice” with regards to the issues these agencies deal with. The creation of advisory councils is set within the agency’s structure and councillors participate in a voluntary scheme. However, members of advisory councils are invited by the government, meaning that these spaces are not open to any citizen willing to participate. They do not have decision-making powers and only act as consultative and information-sharing spaces.

Mediatory spaces between society and government authorities may also be created by the initiative of citizens. In Mexico City, for example, the Citizen Council of Public Safety (*Consejo Ciudadano de Seguridad*) was created in 2007 through an agreement with the City’s government and a group of people organised in the NGO “Common Front to Fight Delinquency” (*Frente Común contra la Delincuencia*). This group of approximately 30 people act as “citizen councillors”. They come from different sectors of society, although mostly from the middle class, such as industrial, commercial, NGO, and services sectors, and with professions such as barristers, notaries, and academic researchers. The council provides “advice and analysis on public safety issues, obtaining and administering justice, civic culture, and support to crime victims, among other issues”.¹⁶¹ The aims of the council are to work with local authorities in programmes to fight crime. It has a hotline where individuals can denounce a crime or make a complaint related to the judiciary authorities and the police. It has a large base of volunteers that act as “neighbourhood citizen councillors”, who take their issues of concern to the council. Through open announcements to recruit volunteers, the organisation had 94,000 registered neighbourhood councillors as of May 2009 (Consejo Ciudadano de Seguridad Pública and Procuración de Justicia del Distrito Federal 2009).

The use of New Democratic Spaces, especially those created by governments, is still very weak in Mexico. None of them resemble the deliberative character of emblematic cases like participatory budgeting in Porto Alegre. Mexico City citizens seem to prefer to create their own spaces, such as the Citizen Council mentioned above, or to resort to other channels like the Human Rights Commission. In 2010, several social organisations, like *Patronato de San Ángel* and *Voz Ciudadana*, put

¹⁶¹ Consejo Ciudadano de Seguridad, <http://www.consejociudadanodf.org.mx/quienes.php> accessed 05/08/2010.

forward a claim to the Commission in order to defend their right to have a say in determining the land use of their neighbourhoods (Bolaños 2010; Robles 2010). The reform of the Law for Urban Development, approved by the local Assembly of Representatives, limits the power of neighbours to reject land-use and planning permissions. Other organisations, like *Pro-Vecino*, have used mass media mechanisms to channel their claims to authorities.¹⁶²

Despite the availability of some institutionalised spaces for citizen participation, these do not provide real influence over policy to citizens. Decision-making is still reserved for government officials and/or politicians. Citizens' voices are taken only as advice rather than as a policy. New Democratic Spaces with real citizen power entail deliberation over issues that are then translated into policies. Mexico City citizens seem disinterested in participating through government-created spaces, as the case of neighbourhood committees suggests.

The overview of citizen engagement mechanisms available in Mexico City is not very encouraging, as this section described. But how different is participation in the health sector? The next section looks at this sector in particular, to find out how citizens and CSOs can influence the implementation of health policies.

7.3 Citizen participation in the health sector

In Mexico City, there are three main forms of citizen participation in health policy. One is through institutionalised spaces, where civil society representatives are invited by members of regulatory or advisory councils. Another one is through the collaboration of NGOs with government agencies like the Department of Health. The third relates to the accountability of health care providers, whereby individual citizens take action to ensure their accountability. This section describes the different ways in which citizens may have a say in health policy and service delivery. It uses the two case study policies to illustrate the collaboration of NGOs with the Department of Health. Accountability is addressed by the channels available to citizens in order to make complaints about health care services in general, as well as those specific to the PHI and the ILE policies.

¹⁶² <http://www.provecino.org.mx/> accessed 05/08/2010.

Regulatory and advisory councils – invited spaces

The most important and influential council in the Mexican health sector is the General Health Council (CSG). It is at the top of the health policy hierarchy. It only responds to the President of the country, and it is the President who appoints its members. The General Law for Health (Art. 15) states that the CSG must be presided over by the Minister of Health in turn. It must also have a secretary and 13 councillors - two of these must be representatives of the National Academy of Medicine and the Mexican Academy of Surgery. The internal regulation of the CSG adds one more civil society member, the head of the National Autonomous University of Mexico (UNAM). Other councillors are the Ministers of Education, Economic Development, Transport and Communications, Treasury, Social Development, Social Assistance Services, Agriculture and Rural Development, Environment, as well as the heads of social security institutions (IMSS and ISSSTE). The core 13 councillors vote on all decisions made by the council and these decisions are binding countrywide. The CSG also includes members who can comment but do not have voting power. Most of these are civil society representatives, such as the think-tank Funsalud, the Association of Universities, the National Association of Private Hospitals (ANHP), the Pharmaceutical Industry Association, and other medical professional associations.¹⁶³

The main responsibilities of the Council are to make public health policy and regulating health care provisioning. Regarding the latter, the CSG is required to “determine the actions and tools necessary for the evaluation and quality certification of health care providers”.¹⁶⁴ On policy-making, the Council defines the policies that tackle the production, sale and consumption of toxic substances, as well as those that deal with the effects of environmental pollution on health. It is also in charge of defining the catalogue of generic medicines and the basic catalogue of medicines for public health services and social security institutions. Other tasks include providing an opinion or giving advice on public health issues, but these have no binding power. The role of the CSG is very important. However, participation of civil society is only limited to the organisations that are selected to have a seat without voting power.

¹⁶³ Diario Oficial de la Federación. 11 de diciembre de 2009. Reglamento Interior del Consejo de Salubridad General – Internal regulation of the General Health Council.

¹⁶⁴ Diario Oficial de la Federación. 11 de diciembre de 2009. Reglamento Interior del Consejo de Salubridad General, art. 9-XII.

Other sector-wide councils have been created by the state in order to discuss and analyse policy issues. However, these advisory councils do not have factual power over policy decisions. Mexico City has a Health Advisory Council, as well as a Council to Fight Overweight and Obesity (created in early 2010). The majority of councillors are government officials, but civil society representatives are also invited. In particular, representatives of medical associations like the National Academy of Medicine are invited, and so are universities, like the UNAM.

The spaces available to civil society are very limited for policy influence. Only the CSG has any real decision-making powers, since its decisions are binding nationwide. Nevertheless, only a few seats are offered to selected CSOs. Other advisory councils do not have a direct influence on the conduct of health policy.

NGOs, knowledge and collaboration

Sexual and reproductive health is the area with significantly more citizen engagement within the health sector. The ILE and its predecessor, the Robles Law, offer an interesting case to understand the way in which society has influenced the implementation of policies. Furthermore, they are examples of successful partnerships between government and civil society. The feminist movement and women's NGOs have been pushing the sexual and reproductive rights agenda since the 1970s and have been able to make great progress in Mexico City (see Chapter Four).

At a national level, the clearest example of the influence of women's NGOs¹⁶⁵ on health policy is their collaboration and direct involvement in drafting the Mexican Official Norm for cases of violence against women (NOM-046-SSA2-2005). The Norm specifies the procedures for handling these cases by both public and private health care providers. These NGOs succeeded in including the obligation for health care providers to make available emergency contraception and abortion services to victims of sexual violence. Despite this, the Ministry of Health put forward another draft version where health care institutions were not obliged to provide these. Disapproving voices, such as several CSOs, human rights agencies and government officials in other departments, applied pressure in order to have the proposal drafted by the NGOs back in the discussion. The National Congress finally approved the NGOs' version of the bill (Ipas México 2010).

¹⁶⁵ Ipas, CIAM, and *Equidad de Género*, together with Mexfam, and the National Federation of Parents Associations, participated.

Citizen engagement in certain areas of health policy in Mexico City is characterised by strong NGO influence and poor social movement involvement. NGOs working on issues such as reproductive and sexual health, and those that work on domestic violence against women, are very active in advocating and promoting policy changes. However, there is very little engagement by patients or service users' organisations. The only policy area with a significant degree of patient and activist participation is in HIV/AIDS. Social movements in this issue-area collaborate with the City's Department of Health and have been involved in designing and implementing HIV/AIDS policies.¹⁶⁶

The involvement of NGOs in the implementation of sexual and reproductive health policies, such as legal abortion, has been key in ensuring access to these services in Mexico City. Before the ILE law was approved in 2007, abortion was legally permitted in cases of rape and a few other cases such as foetus malformation. Hence, access to legal abortion was restricted. In 1995, an agreement between the Ministry of Health and the Attorney General's office for Mexico City designated three public hospitals to provide health care to victims of sexual violence. However, abortion services were only provided in one hospital, while a second hospital provided the service in an inconsistent way, depending on the "medical director's personal attitudes" (Billings et al. 2002, p.89). But in 2000, collaboration between the government and CSOs proved successful in ensuring access to legal abortion services. In Mexico City, the Robles Law (1999) widened the range of grounds on which abortion was not penalised. Public health services run by the Department of Health needed to make preparations to provide abortion services on a larger scale. To achieve this, the Department of Health was supported by Ipas, an international NGO that works on women's health issues. Also, a group of NGOs lead by GIRE participated in drafting the norms and procedures for the implementation of the Robles Law.¹⁶⁷ Other NGOs were involved in raising awareness. They organised nationwide conferences with medical professionals to discuss the impact of violence against women and the link between sexual violence and legal abortion (Billings et al. 2002).

Ipas and the Department of Health developed a model of care for victims of sexual violence. The model included counselling and medical services to prevent and treat sexually transmitted diseases, as well as to terminate pregnancy, if requested.

¹⁶⁶ Interview with Laurell 24/03/2008

¹⁶⁷ Interview with Laurell 24/03/2008

Ipas ran workshops in the 15 general and mother-child hospitals in the public health sub-system in Mexico City. The aim of these workshops was to raise awareness amongst medical, social-work and administrative personnel of the legal framework for sexual violence. They stressed the centrality of the victim and the range of services victims are entitled to, such as legal, medical and psychological services. The workshops also served to find out about the attitude of medical personnel towards legal abortion and, in particular, about how supportive they were likely to be. Around 80 per cent of workshop participants said they would perform abortions in cases of sexual violence and in other cases defined in the Robles Law (Billings et al. 2002). Nevertheless, the Health Department decided to concentrate abortion services in three hospitals only, with well-trained staff, and with the close supervision of the Secretary of Health herself. In my interview with her, she mentioned that she was very careful with abortion cases: “we wanted it [abortion service] to be implacable because if something went wrong, we would have everyone against us...”.¹⁶⁸ Within three years of implementing the Robles Law, there were 150 abortion procedures carried out in public hospitals, all of them for victims of rape and with judicial authorisation.¹⁶⁹ This work set a precedent for the later operation of the ILE.

The experience of government-NGO partnerships in the implementation of the ILE is similar to the one described above. After the enactment of the ILE, advocating NGOs were interested in making sure that it was properly implemented. “The law by itself doesn’t guarantee access to services”, mentioned the director of Ipas Mexico. The group of five NGOs -GIRE, Ipas, Population Council, Gender Equality, and Mexican Catholics for Choice - participated in drafting the operation guidelines and regulations for executing the policy. They also collaborated in training public hospital staff. Ipas led the organisation of these training workshops with input from the other NGOs. For example, Catholics for Choice presented arguments in favour of making abortion available to women from a religious point of view, while Ipas and the Population Council presented medical data and the legal framework. The aim of these training workshops was to raise awareness, to inform, and reduce the number of conscientious objecting personnel.¹⁷⁰ Counselling to abortion patients was a central topic in trainings for social workers and medical doctors. Ipas provided technical

¹⁶⁸ Interview with Laurell 24/03/2008.

¹⁶⁹ Interview with former SSDF official 26/04/2008.

¹⁷⁰ Interview with Ipas Mexico director 30/04/2008.

assistance in the use of less invasive and safer methods for inducing abortion, for example, manual vacuum aspiration (MVA) and medical abortion with misoprostol, which are recommended by the WHO, rather than the more risky curettage methods (Billings et al. 2002). This NGO also donated MVA instruments to the Department of Health.

However, a majority of hospital staff still refused to participate in the training claiming conscientious objection. In some cases, the training programme was not even finished due to a lack of participants or hostility towards organisers.¹⁷¹ The success of the training workshops depended on the personal attitudes of the hospital director. Workshop organisers had to negotiate first with the hospital director before they could run the workshop.¹⁷² In order to overcome hostile hospital directors, Health Department officials decided to concentrate efforts on one health centre but without withdrawing abortion services from other hospitals. Training workshops for non-conscientious objecting medical staff are now carried out in this health centre rather than at each hospital. This health centre is well-equipped and all staff, including doctors, nurses, administrative personnel, and social workers, are trained by Ipas.

Support from health-related CSOs for the implementation of the ILE law is wide. The National Alliance for the Right to Choice (ANDAR), a network of CSOs and individuals, has been engaged in the policy. NGOs like GIRE, Catholics for Choice and others, work through ANDAR on disseminating information and raising awareness of the availability of voluntary abortion through media campaigns. Many of ANDAR members' websites¹⁷³ offer a comprehensive guide on accessing abortion in Mexico City's public hospitals. To this end, they distribute flyers, posters and information pamphlets.

The role of NGOs in the implementation phase of the ILE law has been key in ensuring a better service delivery. They have contributed also to raising awareness of the availability of the service so that a wider sector of the population can have access to it. This experience demonstrates well how citizen involvement can contribute to more effective policy implementation.

¹⁷¹ Interviews with Hospital directors and medical staff April-May 2008, January 2009.

¹⁷² Interview with Ipas Mexico director 30/04/2008.

¹⁷³ <http://www.gire.org.mx/contenido.php?informacion=205>;
<http://www.andar.org.mx/minisitio%20andar/index2.htm> accessed 03/08/2010

Accountability – collective and individual mechanisms

A lack of collective citizen participation in accountability activities was found. The health sector in Mexico City does not show strong societal accountability. Societal accountability is defined as “citizen action aimed at overseeing political authorities... a non-electoral, yet vertical mechanism of control that rests on the actions of a multiple array of citizen associations and movements and on the media, actions that aim at exposing governmental wrongdoing, bringing new issues onto the public agenda...” (Peruzzotti and Smulovitz 2002; p.147,150). However, in the case of Mexico City, no relevant collective actions were found, either from patients’ associations or from groups of health care services users. The most commonly used accountability mechanism was through the Human Rights Commissions. This kind of accountability, however, is based on complaints made by individual citizens rather than collectives. Human Rights Commissions (national and local) are defined as “autonomous public organisms”. Although they are created and funded by the state, they are run by citizens. “These public organisms have different degrees of autonomy and certain faculties to watch and control; their purpose, at both national and local levels, is to strengthen the accountability and control of government actions” (Monsiváis Carrillo 2007, p.10).

Mexico has a National Human Rights Commission (CNDH) and each federal state has a state-level commission. The Mexico City Commission (CDHDF) stands out for the defence and strength of its autonomy from the state. It acts as a mediator between society and the state in channelling human rights’ violation claims from citizens to the appropriate government agencies. For violations of the right to protection of health, the CDHDF issues official recommendations to the Mexico Health Department or social security institutions, which may accept these recommendations and make corrections, but they are not obligated to carry them out. Their influence is limited since their recommendations have no binding power.

A large proportion of complaints received by Human Rights Commissions are related to health care. At the federal level, the Commission received a total of 3,480 complaints in the year 2009. The only state institution with more complaints made about it was the army (*Secretaría de la Defensa Nacional*) with 1,791 complaints, followed by the IMSS, the main social security and health care provider in the country, with 701 registered complaints (CDHDF 2010). At the local level, the Commission received 7,760 complaints in the same year. Of the total number of

claims about rights' violations, the right to health care occupies fourth place. The Department of Health is the governmental agency with the highest number of complaints against it. Most complaints, 80.1 per cent of the total, related to the obstruction, restriction or refusal to provide health care; 11.2 per cent related to quality of services, especially lack of resources; and only 3.7 per cent to medical negligence (CDHDF 2010).

This accountability mechanism for holding health care service providers responsible for their actions or inactions has proved to be effective in the case of Mexico City. In 2007, the year the ILE law was introduced, the local Human Rights Commission issued a recommendation to the Department of Health based on several complaints received by citizens. The recommendation (CDHDF 15/2008) addressed medical negligence that caused the death of a minor, deficiencies in staff availability, poor medical services, and refusal to provide information requested by women asking for an abortion. The Department of Health accepted this recommendation. After that, the Commission did not receive any more complaints about the ILE policy services in 2008 and 2009 (CDHDF 2009, 2010).

Accountability actions led or run by NGOs were not found in the two case study policies. It seems that NGOs prefer to influence health policy by collaborating with the government instead of confronting it. As one NGO director mentioned, “we don’t want to be watchdogs but collaborators...”¹⁷⁴ They see more opportunities to have a real impact on services through collaboration than through accountability. By working closely with the government, NGOs such as Ipas, the Population Council, and GIRE, have gained access to the register of ILE policy service provision. These NGOs use that information to monitor services. If they find a case where abortion was denied or unnecessarily delayed, then they track it.¹⁷⁵

Other accountability efforts come from government initiatives. At the national level, mechanisms have been created to encourage civil society involvement in ensuring the quality of health care. The Ministry of Health introduced the “citizen guarantor” scheme in order to engage civil society actors in monitoring health services. The idea was to “build citizenship around health care services”¹⁷⁶ with a focus on the quality and accessibility of these services. The citizen guarantor acts as a

¹⁷⁴ Interview with Ipas Mexico director 30/04/2008

¹⁷⁵ Interview with GIRE director 05/04/2008

¹⁷⁶ Interview with SSA official 02/05/2008

mediating mechanism between the health care institution and the users of its services. The aim is for every hospital and health centre (including social security institutions and private providers) to have a citizen guarantor. A citizen guarantor should be a recognised organisation or group of individuals that work in areas of public interest. Efforts to introduce the scheme have concentrated on public health care institutions under the management of the Ministry of Health and state health departments. In order to be certified as a PHI provider, hospitals are required to have established the citizen guarantor scheme.

In Mexico City, the citizen guarantor scheme has reached federal and local hospitals but not primary care health centres. Experiences with the scheme vary from provider to provider, but it is generally weak and without any impact on quality of services. Hospital directors decide whether to put observations made by the citizen guarantor into practice or not. Three of the interviewed public hospital directors mentioned having a positive experience with the citizen guarantor scheme. One of them is a federal public hospital. The UNAM School of Psychology acts as a citizen guarantor for this hospital. Students and teachers of the school have regular contact with the hospital and write quarterly reports with their observations about service delivery. The collaboration between the school and the hospital goes beyond the citizen guarantor scheme. The school also runs workshops on organisational psychology and stress relief for the hospital administrative staff.¹⁷⁷ Another successful example is a local public hospital where community involvement was strong even before the introduction of the scheme. A group of neighbours in the area act as citizen guarantors in this hospital. The group of neighbours is well recognised for its commitment and involvement in issues affecting the community. They carry out surveys with patients at different times of the day in order to capture users' experiences with the services provided at different shifts. The results are then reported back to hospital authorities twice a year.¹⁷⁸

For the majority of hospitals interviewed, it was difficult to find a CSO willing to act as citizen guarantor. The organisations they approached were simply not interested in participating or claimed to not have enough time to commit to the scheme. Therefore, these hospitals turned to medical schools or universities, as it was easier to convince them to participate and commit. The director of a hospital located

¹⁷⁷ Interview with hospital director 26/05/2008

¹⁷⁸ Interview with hospital director 19/01/2009

in the city centre mentioned that he had been unable to find a citizen guarantor because the relationship between the hospital and the community was very weak. He stated that “the situation here is more complicated, most patients do not live in the area, they just come to work here”.¹⁷⁹ Hence, there was no sense of cohesion or ownership among service users.

The Mexico City case shows that, even though mechanisms for holding service deliverers to account are in place, citizens may not participate for various reasons, such as lack of time and interest or community cohesion. Organised citizens, such as NGOs, are more interested in collaborating with the government rather than confronting it. The mechanisms that seem to appeal more to citizens are the Human Rights Commissions, where they can put forward complaints regarding poor service delivery. This type of mechanism requires individual citizen involvement rather than collective actions or organised groups of people.

Individual actions to ensure the accountability of service providers, therefore, seem to be preferred. Other governmental mechanisms are also in place to hold health care providers to account. The PHI policy established managerial mechanisms to channel users’ complaints to the relevant service provider. Policy guidelines include setting up telephone hotlines and complaint mailboxes. At the national level, the Ministry of Health has a special department to mediate between patients’ complaints and health care providers. These channels connect directly with the individual rather than with a collective or citizen organisation.

The Ministry of Health has an official space for the mediation of doctor-patient disputes. The CONAMED (National Commission of Medical Arbitration) depends on the Ministry of Health and is in charge of dealing with medical negligence claims from patients. It does not have judicial powers to punish those responsible. Instead, it brings patients and doctors together to reach a compensation agreement. If this is not achieved, then it is in the patients’ hands to take the matter further to a civil or criminal court. In the year 2005, the CONAMED received a total of 1,661 complaints (993 in Mexico City alone), from which 47 per cent reached a conciliatory agreement (Tena Tamayo and Manuell Lee 2006, p.501,513).

In the PHI case, the central office has a telephone hotline for receiving patients’ complaints about services. The hotline channels complaints to local policy

¹⁷⁹ Interview with hospital director 21/05/2008.

coordinators for them to take action. In Mexico City, the PHI coordination has its own hotline too. They receive approximately 150 calls daily but 90 per cent of them are about information requests. According to the Mexico City PHI director, all of the complaints have been addressed.¹⁸⁰ Hospitals also have a desk providing information about the programme and receiving any complaints or queries about services. In addition to this, hospitals and health centres have a mailbox where patients can put their comments in writing. Moreover, the PHI guidelines suggest the introduction of a “medical adviser” (*gestor médico*) in each hospital and health centre. The aim is for this person to act as mediator between patients and medical staff at the time of service delivery. Any requests, doubts, complaints, or comments from patients can be taken to the medical adviser. It is a way for patients to feel accompanied and having someone to speak for them.¹⁸¹ However, at the time of research, there were only seven medical advisers for the whole of Mexico City.

Citizen engagement observed in the health sector can draw on different mechanisms for influencing policy and service delivery. However, their real impact on health policy is limited. Most citizen-participation mechanisms do not have any binding power on service deliverers and they are only able to implement changes. Advisory councils and accountability mechanisms may offer a degree of legitimacy towards society, since service providers and health authorities can say they have considered civil society voices. The kind of managerial mechanisms for accountability used in the case of the PHI policy actually reduce the influence that patients may have over service delivery. This is because it is the same health provider who receives the citizens’ complaints. Managerial approaches were originally designed for increasing client satisfaction in competitive markets. The more managers know about their clients’ needs, the more they can adapt their services to attract more clients. However, in the public health care sector there are no such market conditions. Knowing service users’ needs becomes relevant only to those managers with the will to do so, since there are no binding rules or incentives for addressing patients’ needs and complaints.

Collaboration of NGOs with the Department of Health illustrates a more promising way to have an impact on health policy and service delivery. NGOs have been particularly successful in the area of sexual and reproductive health. Their expertise has helped the government in drafting bills and policy guidelines for

¹⁸⁰ Interview with PHI director for Mexico City 12/03/2008.

¹⁸¹ Interview with PHI director for Mexico City 12/03/2008.

implementation. They have also trained staff and donated equipment for the ILE. These actions have improved abortion service delivery in public hospitals, as Chapter Six explained.

Medical professionals are central actors in the provision of health care services and are often the target of patients' complaints. They are key actors of the health system and could well influence policy if organised as a civil society entity. However, no participation of medical associations was found in Mexico City. The next section analyses the role of medical associations and the probable reason for this lack of involvement in health policy processes.

7.4 The medical professional associations

Health care delivery is only possible through medical experts. Doctors and nurses are a key asset for any country. Hence, the role they play in health policy processes is crucial. In Mexico, however, participation by medical professional associations in policy processes is limited and incipient. The most renowned of these associations in the country are the National Medical Academy of Mexico (ANMM) and the Mexican Surgical Academy. Both of them have seats in the CSG with voting powers, and they are often also invited to participate in local level councils such as the Mexico City Advisory Health Council. These associations enjoy a high degree of prestige and provide popular legitimacy to these councils.

However, they do not get involved in other areas of citizen engagement in health policy. Even in important and controversial policy areas, such as the PHI scheme and the ILE, neither the ANMM nor the Surgical Academy, nor indeed any other medical professional associations, were engaged in the debate or tried to influence these policies. Only three years after the enactment of the ILE, the ANMM made a statement regarding its position towards this policy. This Association published a statement in national newspapers in April 2010, only after another prestigious professional association, the Mexican Scientific Academy, did so in January the same year. The Scientific Academy statement specifically referred to the reforms carried out in eighteen states to strengthen the criminalisation of abortion as a reaction to the reform in Mexico City (see Chapter Five). The Scientific Academy expressed its concern with the "regressive phenomenon that during the past months has undermined the county's political rationality". The statement went on to say that

these reforms were a violation of the principles of the secular state, and that they were based on a “simplistic, arbitrary and little informed definition of life.”¹⁸² The statement by the ANMM referred to reproductive health and women’s rights. It mentioned that the Association was “decidedly in favour of women’s and couples’ free choice on reproduction, and the implementation of public policies that encourage all possible preventive measures, including access to information and to the widest possible range of contraceptive methods.” It continued to express its strong opposition to “the criminalisation of women that face the decision to terminate a pregnancy that is unplanned, unwanted, forced, or that is a hazard to her life or physical, mental or social wellbeing”.¹⁸³

The most basic degree of involvement in policy issues is to put forward one’s position in the policy debate. These key professional associations have done so, but their engagement in this policy issue does not go further. Their strong statements came more than three years after the abortion legislation was in the public arena. The reasons why these associations waited so long to make a statement about their positions are unclear.¹⁸⁴ Nevertheless, the potential impact of these statements on improving the implementation of the ILE policy is high since they can provide moral support to non-conscientious-objecting medical practitioners.

There is a generalised lack of engagement in health policy debates among associations of medical professionals in Mexico. When the PHI scheme was discussed in the National Congress and later put into practice, medical associations did not get involved or even make a statement about it. Despite the lack of interest in participating, the majority of doctors I interviewed for this study complained about the programme, especially about the services’ package and the definition of interventions included in the insurance scheme. The same lack of involvement was observed in the case of the ILE policy. There was no involvement of any medical association during the public hearings organised by the Supreme Court of Justice when the unconstitutionality of this law was being discussed (see Chapter Five). These hearings were characterised by a high participation by CSOs, but none of these were medical professionals’ associations. From a total of 80 presentations, 54 (67.5 per cent) were

¹⁸² “Pronunciamiento de la Academia Nacional de Medicina de México ante la salud reproductive y los derechos de la mujer”, <http://www.anmm.org.mx/>, accessed 10/08/2010.

¹⁸³ Op cit.

¹⁸⁴ It was not possible to interview them in order to ask about this.

by CSOs, 13 by political parties, 4 by government officials, 8 by individual citizens and one by a law firm. CSOs that participated were mainly advocacy organisations on issues like feminism, sexual and reproductive rights, family values, Pro-life, etc. Also, research centres, universities, and law professional associations participated in the public hearings (GIRE 2009).

Medical staff working in the local public health care units had not been engaged with authorities about the design or implementation of either the PHI or ILE policies. None of the hospital directors and doctors I interviewed had had a say in those issues despite their central role in carrying out the policies. The union of medical personnel in the Mexico City government was not involved in the operationalisation of the ILE policy either. They were only expected to carry it out. The government official responsible for this operationalisation in the Department of Health mentioned that the union was never involved; “I didn’t even have a meeting with them”, he mentioned.¹⁸⁵ However, two hospital directors interviewed¹⁸⁶ mentioned that they knew the union offered advice to members about conscientious objection, but I was unable to corroborate this information.

It is common for doctors and specialists to be organised in councils and associations. Most medical specialisations have a council that is in charge of certifying and re-certifying doctors in order to ensure professional standards. These peer-to-peer certifications are recognised by public and private establishments. Medical associations, also by specialisation, are membership-based and their aim is to provide up-to-date training, workshops and conferences to discuss new trends in the speciality. These types of professional associations do not get involved in health policy processes. Their only interest is in medical practice issues from an academic perspective. They seem to avoid any policy-related or political issues. For example, the Mexican Association of Gynaecology and Obstetrics Specialists (COMEGO) did not discuss the ILE policy amongst its members.¹⁸⁷ There is no reference to it at all in their website.¹⁸⁸

¹⁸⁵ Interview with SSDF official 08/05/2008.

¹⁸⁶ Interviews with hospital directors, May 2008.

¹⁸⁷ Interview with COMEGO member 19/05/2008.

¹⁸⁸ http://www.comego.org.mx/index.php?option=com_frontpage&Itemid=1 accessed 16/08/2010

Explaining the medical profession's disengagement

In Mexico, and especially in Mexico City, other public service areas such as education and housing have significant participation from those involved in policy implementation: teachers and students, neighbourhood associations, and so on. Therefore, why is it that the health sector has so little involvement of patients and medical practitioners? One of the reasons is found in the background of the relationship between medical professionals and the state. There is a tense relationship between these two actors that dates back to the 1960s when a medical movement was crushed by the state. This section describes the 1964-65 medical movement and its consequences. This description is based on the extensive work of Ricardo Pozas Horcasitas (1993) on the subject.

The 1960s was a period of civil unrest in Mexico, as in many other countries. The decade was characterised by social movements fighting for democratic liberties and repression as a response from the state. In Mexico, the first major social movement was held in 1964-65 by medical practitioners - resident and intern doctors - working in public institutions. The movement began with the strike by approximately 170 doctors in a social security hospital (ISSSTE) fighting for better labour conditions (contracts, salaries, working hours) and for inclusion in institutional decision-making and the design of medical schools' curriculum. The same day they announced the strike, they were all dismissed. The movement started escalating, with doctors in other hospitals going on strike in support of their colleagues. They formed the Mexican Association of Medical Residents and Interns (AMMRI) in order to channel their claims to the state. After only a couple of weeks of the first strike, 23 hospitals were on strike in Mexico City and 20 more in other states. Medical professional associations expressed their support for the claims of the young doctors. So did the medical associations in public hospitals, who were fully-trained doctors and specialists supporting the AMMRI. These medical associations called similar associations throughout the country to be part of a medical professionals' national alliance, instead of being part of civil service unions. The Alliance of Mexican Medical Professionals (AMM) was constituted in 1965 and the AMMRI became part of it. For the first time in the history of Mexico, medical staff in public health care services came together under a single organisation.

The medical movement challenged the Mexican corporatist state and it suffered the consequences. The medical movement ended with the police taking

strikers out of hospitals by force. The Alliance and the movement were unable to resist the pressure from corporatist organisations within the health sector, such as the IMSS and ISSSTE labour unions, and the confrontation with the state. The success achieved during the movement, regarding better salaries and contractual terms, was not observed after the end of the last strike and the previous contractual terms with medical residents and interns were reinstalled. Active participants in the movement were permanently dismissed from their jobs and prosecuted for civil offences, or even arrested. Three AMMRI leaders had to flee the country to avoid being jailed. Those who were lecturers at UNAM were also dismissed from the university. The names of strikers were blacklisted in public health care institutions across the country to avoid their future re-employment. Leaders of the Alliance were dismissed from their posts in hospitals and substituted by civil servants loyal to the corporatist state. Other participants were co-opted through economic rewards and job promotions.

The consequences of the medical movement crush can still be seen today. Medical professionals are part of civil servant unions and there are no national independent organisations that resemble the short-lived Mexican Medical Professionals Alliance. The corporatist state was very effective in dismantling the medical movement to the extent that, after its fall, medical professionals would not engage in collective and political action.¹⁸⁹ As Pozas Horcasitas (1993) asserts:

The medical profession was regulated within the public health system and control mechanisms ruled the means of medical education. Professional cohesion yielded to authoritarian coercion. The bureaucratic norm permeated with its vices all activities in hospitals; the disrupted norms and values, together with the harassment and the disappointment, stabbed the medical movement with irreversible effects and the possibility of service was turned in to a reiterated routine. (p.331)

To fully understand the reasons why medical professionals do not engage in policy processes as active political actors, further research needs to be done. But the history of the medical movement is indeed still a central issue today. Another key factor to look at is the role of medical schools in the development of the attitudes of the medical profession. Medical schools play a fundamental role in transmitting ideas and

¹⁸⁹ Interview with medical movement activist 23/01/2009

values. Greater involvement of medical practitioners in policy issues could be fostered in medical schools.

7.5 The role of medical schools

Human resources training is a central component of any health system. An appropriate medical education system must be in place in order to ensure a degree of quality in the delivery of health care. Medical schools are responsible for providing good doctors and specialists to society. For health policy implementation, their role as developers of future implementers is very important. The case of the ILE policy is a clear example of how medical schools may indirectly influence policy implementation. One of the main obstacles in the implementation of the ILE policy is the lack of doctors willing to perform abortions. Additionally, those willing to participate in it need training in the methods used in abortion procedures. This reflects the lack of proper training and the prevalence of certain values and beliefs in medical schools that do not encourage informed debates. This section analyses the role of medical schools in training doctors and transmitting values and beliefs that can constrain the effective implementation of health policies.

Several interviewees mentioned the Hippocratic Oath as their moral standard and the reason why they are against voluntary abortion. The centrality of the Oath and its interpretation is given to doctors in medical schools. By taking the Hippocratic Oath, the medical doctor commits to favour and do-no-harm to his/her patients. Rivero and Paredes (2003) argue that this is a paternalist approach to medical practice, where the doctor decides what is best for the patient without considering the patients' rights and autonomy, and their ability to decide what is best for themselves (p.50). With this paternalistic approach, which is dominant in Mexican medical schools, doctors do not see a woman asking for an abortion as able to decide on her own about what is best for her. Also, in the belief that the product of conception is a human being, doctors then apply the do-no-harm principle to it and refuse to perform abortions.

Furthermore, medical education in Mexico is deficient in the area of sexual and reproductive health (González De León et al. 2008). It does not consider induced abortion as an integral part of women's reproductive health. Hence, students do not learn the most advanced methods and technologies. The doctors I interviewed

concurred that, when they attended medical school, those issues were not taught or even addressed. They were only taught about dealing with miscarriages. González De León, Billings *et al.* (2008) conducted an analysis of the curriculum of eleven public medical schools, with particular attention to their gynaecology and obstetrics specialisation. They found that those curriculums are based on a curative approach, are fragmented and focus on hospital practice. Their model privileges clinical disciplines and neglects the relationship of medicine to social sciences and public health (p.262). The authors identify the reasons why important issues on women's health are not covered in medical schools: the reluctance to change, the overload of topics in curriculums, the lack of qualified teachers, gender biases, and the idea that these topics are of no interest to medical students (p.262). With the decriminalisation of abortion in Mexico City in 2007, most universities now address the legal aspects of abortion and the rights that medical practitioners have to refuse to perform abortions.

Gender and age biases are problems in the medical profession, both in education and in practice. The profession is dominated by conservative middle-aged men who occupy high positions in medical academies, councils and associations. Very few women have relevant power positions in the profession.

Apart from these biases, the most relevant factors that influence medical education are the personal values and beliefs of those in front of a class and the institutional principles that medical schools have. Most prestigious private medical schools are Catholic, hence abortion is equated to homicide. Examples of these universities are the *Anáhuac*, belonging to the Legion of Christ; the *Panamericana*, from the Opus Dei; and *La Salle* from the Brotherhood of La Salle. These Catholic organisations, especially the first two, belong to the most conservative side of the Catholic Church. They have an open Pro-life approach in their medical schools. La Salle Medical School director stated in a press interview that "as an institution based on a Catholic-Christian philosophy, respect for human life is essential". In a similar vein, the bioethics director of the Panamericana Medical School stated that "it is proven that human life begins at the moment of conception" (Gómez Quintero 2010). This university has a course entitled "Alternatives to Abortion" where students are taught to provide advice to women with an unwanted pregnancy on different solutions to their situation. On the other hand, in public medical schools the basic principle is secularity, therefore, the approach to abortion depends on the lecturer's values and beliefs. As UNAM lecturer, Joaquin Ocampo, puts it:

...it is a risk and a challenge for us lecturers to have enough moral maturity so that above our own convictions and facing dilemmas like the voluntary termination of pregnancy, we can be able to go beyond, thinking that we are not indoctrinating future doctors but presenting a panorama about which we have to reflect. (Gómez Quintero 2010)

In UNAM, they claim to teach students that the policy for voluntary termination of pregnancy is based on the secularity of the state. The Medical School of UNAM is one of the few that actually includes MVA training for induced abortion in the curriculum (González De León et al. 2008).

The education of medical practitioners is fundamental to strong health care systems. The effectiveness of health policy implementation is greatly determined by the behaviour of service providers, which is based on their personal values and beliefs. Medical education needs to be aligned with health policy-making so that medical schools can generate the human resources that the health system demands.

7.6 Conclusion

This chapter examined the different spaces that civil society may use to influence health policy. It presented an overview of the nature of Mexican civil society so as to locate the most relevant social actors involved in health care. It showed that citizen engagement in health policy was very weak and that citizens had little impact on health service delivery.

NGOs seem to be in a better position to have a greater impact on policy implementation. In the case of the ILE, a group of NGOs that work on sexual and reproductive health issues has collaborated closely with the government. Their involvement had a real impact on the way policy has been carried out by public health care providers. They drafted bills and implementation guidelines for policies on legal abortion and violence against women. They also trained medical staff in abortion techniques. All of this has enabled more effective policy implementation.

In other areas of health care, such as access to services by the uninsured population (the PHI policy issue), civil society involvement is weak. The PHI has managerial mechanisms to deal with client dissatisfaction, linking up with individual citizens, but disenabling collective engagement. In the case of the ILE, hotlines and complaint mailboxes were used to hear citizens' voices. The impact of this type of

accountability mechanism is very limited since there is no obligation to address complaints made.

In both policies, what seemed to work best for accountability purposes were the Human Rights Commissions at both local and national levels. Although institutionalised by the state, they offer a space to citizens and have a good position to have their voices heard by the authorities. However, their recommendations to health care institutions have no binding power and they may not result in service improvement. The same happens with advisory and regulatory councils where civil society representatives have a seat. It is left to health care authorities to put into practice what these councils propose, therefore changes are not assured.

This chapter also analysed the roles of medical professional associations and medical schools in policy implementation. An unexpected and yet central finding in this study is the lack of participation by medical associations in policy processes. The centrality of medical practitioners in delivering health care services should be a reason for active participation. However, by looking back in history and understanding the background of medical professionals' associations and their relationship with the state, this lack of political involvement becomes clearer. Nevertheless, younger generations could be more interested in health policy. And here is where the role of medical education becomes fundamental. In Mexico, the training of human resources for health care seems unsuitable in some areas for the current health system needs. At least in the areas of sexual and reproductive health, the disconnection between medical education and health policy constrains the proper implementation of policies. Medical schools are not addressing the needs of the national health sub-systems and are providing human resources that are not in tune with the current design of health policies. Greater communication and collaboration between policy-makers, health authorities and medical schools is crucial in order to achieve a coherent health system in the long run, and more effective implementation of policies in shorter terms.

8 Conclusion

Public policies sometimes are not carried out the way policy-makers intended. Well-designed policies may not produce the expected outcomes, or may result in poor service delivery because of ineffective policy implementation. Although the reasons for poor delivery of services vary, having a deeper understanding of the implementation process may provide answers as to why those in charge of putting policies into practice fail to do it. This problem has been a concern for policy analysts and researchers for the past four decades. Policy implementation is still “the missing link”. This thesis aimed to better understand the process through which policies are translated into practice. By having a deeper knowledge of these processes, it is possible to enhance the factors that contribute to more effective implementation and reduce the influence of those that constrain it. In this way, the delivery of public services can also be improved.

The main goal of this thesis was to bring to light the factors that contribute to the success or failure in translating policy into practice, and how those factors influence such processes. The research questions that this study followed are: How are health policies in Mexico City put into practice? What factors may enable or constrain the effective implementation of policies? The analysis focused on four factors: actors involved and their ideas and beliefs, service delivery arrangements, managerial practices in place, and citizen participation and accountability of service providers. Elite and specialised interviews were carried out, as well as literature reviews, and document and official proceedings analysis, in order to answer these questions. Two specific health care policies being implemented in Mexico City served as case studies: the PHI programme and the ILE. Both health policies posed challenges for their implementation but in distinct ways. The PHI programme needed the collaboration between federal and local health authorities. The policy for voluntary abortion had a moral and ethical dimension that required support mainly from service providers. The PHI programme was enacted in 2003 by the Union Congress and aimed at providing health care services to the population without any social security. The ILE law was

introduced in Mexico City in 2007 by the local Assembly of Representatives (local congress). This policy decriminalised voluntary abortion during the first trimester of pregnancy. Its enactment was celebrated by reproductive rights activists but condemned by the conservative party holding power at the federal level.

The thesis argued that actors' values and beliefs influence not only morally charged policies, but also those less contentious health policies. Most, if not all, public policies have an underlying set of values that shape them. A comprehensive policy analysis, therefore, must include the ideas and beliefs underlying a policy. Ideological factors are not only relevant in agenda-setting and policy design processes, as commonly found in public policy analyses, but are also relevant throughout the policy process. This research demonstrated the relevance of ideas, values and beliefs for policy implementation. It used the ACF to understand beliefs systems that hold coalitions together and explain how they influence policy implementation.

The research also observed other factors that can affect processes of policy implementation: service delivery arrangements, management practices, and citizen participation. Different bodies of literature cite these as key factors in public policy and service delivery. Multilateral organisations, in particular, have been suggesting service delivery reforms to include decentralisation and contracting-out. The mainstream literature in public administration, the NPM, calls for corporate practices to be introduced. At the same time, a body of literature based on deliberative or participatory democracy argues in favour of citizen engagement in public policy. The thesis built an analytical framework based on these theoretical approaches in order to examine policy implementation.

Previous chapters analysed and presented the research findings. This concluding chapter brings together key points raised in each of the chapters and puts them into the wider debate of these bodies of literature. The chapter discusses the empirical and theoretical implications of research findings. It starts with a brief summary of those findings, to then explain their meaning to policy implementation studies and other theories addressed in this thesis. The chapter also offers some policy recommendations and lessons learnt. It ends by highlighting areas that would benefit from further research.

8.1 Summary of research findings

In this section, each of the sub-questions introduced in Chapter One are answered. All together, these questions suggest a way of understanding and answering the main research question about policy implementation. The main research question asked how public health policies are translated into practice in Mexico City. The analytical framework proposed in this thesis may well be useful for any kind of public policies in different areas and countries. However, research findings should be considered within their context and limitations. Some of them are particular to the case of Mexico City and should not be generalised. Nonetheless, theoretical implications that derive from them are relevant for the debate in the wider literature, as explained in the following sections of this chapter.

How is policy translated into practice?

Decision-makers often expect implementers to carry policies out without any problems or constraints. However, it is most common to see that policies are not carried out as intended by decision-makers. This thesis identified two analytical levels to better explain how policies are put into action. The operationalisation level is where, after a policy is enacted, norms and regulations are set, contracts with service providers are drawn, personnel are trained, and so on. The service delivery level is where policy services are actually provided to the population, where implementers meet face-to-face with beneficiaries. The kinds of factors involved in each level are considerably different. To explain how policies are translated into practice means explaining those levels of analysis and how different factors influence the process.

Context first – the Mexican Health System

Very little research exists in the Mexican literature about health policy implementation, particularly about the two policies observed: the PHI and the ILE. The thesis contributes to the literature on health systems and health policies in Mexico and, at the same time, provides lessons to other developing countries. Understanding the context of the policies analysed was very important for this research. Chapter Three examined the Mexican health system. The way services are actually delivered to the population is central for analysing policy implementation. Because of the plural and fragmented nature of the Mexican health system, it was impossible to categorise it

following existing classifications of health systems in the world. It was found that, in Mexico, several sub-systems co-existed in parallel serving different sectors of the population. There was no single category that could explain it, but rather a set of categories that described each of the parallel sub-systems. Five sub-systems were identified: social security institutions, public health care institutions, private sector, non-profit sector, and traditional medicine. Very little interaction and collaboration amongst the sub-systems was found in the Mexican case. The implications of this fragmentation are discussed later in this chapter.

Who is involved in advocating and implementing policies? What are their ideas, values and beliefs about those policies?

Chapter Four analysed the configuration of advocacy coalitions involved in the case study policies. It mapped out key actors, their ideas and beliefs, in both policy processes and how they relate to each other. Two rival coalitions were identified in each policy area. In the access to health care area, the New Public Health coalition clashed with the ideas of the Social Medicine coalition. In the sexual and reproductive health area, the Pro-choice and Pro-life coalitions differed in their core values and the policies they supported. Coalitions helped individuals to get hold of strategic positions in government. The resources available to coalitions explained their influence and capacity to change or affect policy processes, including implementation. These resources were a source of power to steer health policy in the direction each coalition preferred.

Chapters Five and Six addressed the actual process of policy implementation. Chapter Five analysed implementation at the operationalisation level, while Chapter Six analysed the service delivery level.

How is service actually provided? Do private and third sectors participate?

Building on the contextual chapter about the organisation of the Mexican health system, it was found that decentralisation was the main mode for service delivery in the two case studies. Chapter Five explained how tensions between the federal and local levels of government constrained the implementation of both policies under study. These tensions arose from the ideas and beliefs that actors had towards the policy in question. The analysis of advocacy coalitions revealed the different ideas

and beliefs of policy actors. The participation of private and third-sector providers in extending access to policy services was also addressed. It was found that the participation of these sectors was very limited and the reasons for getting involved varied. For private providers interviewed, it was not only profit-making that was important in deciding whether to participate or not, but also having a good reputation and prestige within society mattered. In the case of third-sector service providers, for the organisations interviewed, it was very important to share the ideas underlying the policy. Third-sector health care providers were ideologically-driven rather than profit-driven.

What managerial practices are in place and do they work?

It was found that weak, or no, managerial practices were in place within public health care providers. Chapter Six showed how the actions and behaviour of front-line implementers, that is, medical and administrative staff, were central to delivering policy services. Although the influence of managerial practices on members of staff's actions and behaviour was impossible to assess, the lack of strong managerial practices to influence staff behaviour was a factor that constrained policy implementation. It was found that those actions and behaviour were determined by the ideas, values and beliefs that implementers had about the policy they were supposed to carry out.

Do citizens participate in policy implementation? How are providers held into account to service users?

The last empirical chapter outlined the institutionalised spaces and channels available to the citizens of Mexico City to engage in public policy processes. Although there were relevant spaces, it was found that real impact on policy was very limited. No accountability mechanisms with binding power were found. Also, the participation of CSOs was weak. Only in the case of the ILE law was involvement of a group of NGOs observed. Neither did other key civil society actors, such as medical professional organisations and medical schools, get involved in either of the policies under study. This could be explained by the crushing of the medical movement in the 1960s. It was found that, because of the effects of that historical event, medical associations were not interested in engaging in health policy politics. The lack of civil

society participation and service provider accountability hindered the implementation of health policies.

The thesis findings show the centrality of ideas and beliefs of both key actors and front-line implementers in ensuring a more effective implementation process. However, the other factors were also relevant. The following section focuses on the implications of these findings on policy implementation, both empirically and theoretically.

8.2 Implications for policy implementation

This study highlights the role of ideas, values and beliefs of policy actors on implementation processes beyond agenda-setting and policy design. Implementation studies have been concerned with understanding how policies are translated into actions as this, in turn, affects policy outcomes. This is important because it helps to improve service delivery and achieve expected goals. They have focused on the interplay of politicians, administrators and service providers. In the cases observed in Mexico City, this interplay was mainly determined by the ideas, values and beliefs of individuals.

Implementation studies have moved beyond the top-down vs. bottom-up debate to a third generation of studies that aim to reconcile both approaches. This thesis contributes to the so-called third generation approach. By defining two analytical levels, this thesis combined the first two approaches. The operationalisation level takes a top-down approach as it focuses on political elites and decision-makers. In the same way as bottom-up approaches, the service delivery level focuses on street-level personnel and lower-level implementers. Building on Elmore's work (1985 in Parsons 1995), this thesis complemented a forward-mapping with a backward-mapping analysis, taking into consideration the dynamics of implementers at street-level and those of politicians and managers.

This thesis argued that policy implementation is a political process rather than a logical sequence or chain of activities as the rational control model defines it. Although the analytical framework used here combined first and second generation approaches, it challenged the dominant view of the rational control model. This view is characteristic of top-down or first generation approaches. They argue that if implementation fails it is because the strategy or instruments were wrongly selected,

operationalisation was poor, or there was an inadequate response to problems. The thesis findings challenge this view. It shows that implementation failure or ineffectiveness is determined not so much by wrong mechanisms, but by the individuals in charge of carrying the policy out. Even more, findings suggest that the ideas, values and beliefs of implementers in charge of both operationalisation and service delivery of the policy are central in determining effective implementation.

The thesis assessed effective policy implementation in terms of access to services and capacity of providers to deliver them. The study showed that, among the factors analysed, actors and their beliefs were more influential. The clashes between federal and local authorities seriously affected access to services. Access to the PHI services was delayed in Mexico City for one and a half years because of a clash of ideas between the federal and local health authorities. Federal authorities tried to prevent the implementation of the ILE policy, while also refusing to offer abortion services in federal hospitals, with social security institutions also limiting access to this service. At service delivery level as well, values and beliefs of staff hindered policy implementation in both case studies. Staff behaviour created a hostile work environment to those participating in abortion procedures, which contributed to decreasing the number of doctors available to perform abortions. Primary health care centres in Mexico City were reluctant to join the PHI scheme because they did not agree with its ideological assumptions.

The Mexican public health sub-system showed weak managerial practices in place. These practices are often used in developed countries, such as the UK, to influence staff behaviour and get the desired or expected results in service delivery institutions. With an absence of strong managerial practices in the cases observed, there is no counterbalance to implementers' values and ideas. However, further research is needed to assess the kind of incentives to which implementers would respond. Values and beliefs of staff should be taken into account in order to design relevant performance and control mechanisms. In some cases, changing people's minds could require training and/or experiencing the benefits of the policy rather than monetary incentives or setting performance targets. This is the case of the PHI policy. After street-level staff were able to observe the policy's tangible benefits, such as having improved facilities and more resources to operate, they supported the programme and its implementation was enhanced. Appropriate incentives could motivate different behaviours than the ones reported here, such as hostility towards

those participating in abortion procedures. In both case studies, especially in the ILE programme, street-level staff behaviour seriously constrained its effective implementation, as explained in Chapter Six.

Citizen participation and accountability of service providers was also found to be weak. A more active participation from civil society and individual citizens may enhance policy implementation. The participation of a group of NGOs in the implementation process of the ILE programme contributed to better service delivery in terms of capacity of providers. These NGOs trained public hospital staff in induced abortion methods and techniques, in addition to donating materials and equipment to this purposes. In a similar way, appropriate accountability mechanisms of service providers may contribute to more efficient implementation processes. In the case of Mexico City, the Human Rights Commission was the most used channel by which to make complaints about health services. Even though the Commission does not have binding powers and can only issue recommendations, these had a positive impact on public hospitals offering voluntary abortion services.

In sum, citizen participation, accountability mechanisms and managerial practices are relevant to policy implementation. They can effectively influence the process and improve it. However, findings of this study suggest that the ideas, values and beliefs of individuals at both decision-making/operationalisation and service delivery level have a greater influence in effective policy implementation. The following section discusses other theories included in this study's analytical framework.

8.3 Other theoretical implications

This thesis used the ACF to analyse the actors involved in policy implementation and their ideas, values and beliefs. It also referred to the NPM literature when looking at managerial practices in health care provisioning institutions, and to the wider service delivery literature that argue for more private sector involvement and decentralisation of services. The literature on participatory democracy was addressed when looking at citizen engagement and accountability mechanisms available to influence policy processes. This section discusses the implications of research findings for these theoretical models.

Advocacy Coalitions Framework

This thesis provides a different application of the ACF. It applied the framework specifically to analyse policy implementation, which is not its main purpose. The ACF was devised to explain policy change over long periods of time; however, it proved useful also to analyse policy actors and to identify policy beliefs and supporting ideas. These, in turn, directly affect policy implementation.

This framework was adequate to analyse ideas, values and beliefs of policy actors. By organising the policy arena in issue-areas – in this case, access to health care services, and sexual and reproductive health - it was easier to identify rival coalitions. Coalitions are held together by their core ideas, therefore understanding these helps to make sense of their relationships and actions. Understanding coalitions' ideas and policy beliefs explains, in turn, why coalitions may constrain the implementation of policies advocated by their rivals.

This research identified two policy areas within health policy in a developing country context. Similar studies are scarce. The nature of the Mexican health system reflects the complexity of developing country systems. The existence of parallel subsystems poses a challenge for public policy implementation because greater collaboration and coordination is required. When applying the ACF to this context, different issues emerged, such as the international links of policy actors and the windows of opportunity opened to coalitions. Donors and multilateral organisations like the World Bank and the World Health Organisation have greater influence on developing, aid-recipient countries. These issues are not considered clearly by the ACF. However, as explained above, the framework has relevant strengths.

The ACF has a model of the individual based on belief systems rather than on material self-interest, as the rational choice model argues. This was particularly appealing to the approach of this thesis. Ideas and beliefs better explain, as research findings suggest, the behaviour of those in charge of translating policy into action. The compatibility of the ACF model and other scholars' models, such as Young's (1979) and Vickers's (1968), support the suitability of a model based on ideas and beliefs. The basic structure of these models is the same: deep core ideas that are difficult to change, policy beliefs based on core ideas but applied to more specific problems that influence attitudes and, finally, opinions based on secondary beliefs that are easier to change. This structure explains why, in some cases, changing minds of implementers may be easier than in others. Morality policies, like voluntary abortion,

are based on deep core beliefs that are harder to change. In cases like this, value conflict is more likely to occur. But in policies like the PHI, conflicts of ideas are based on policy or secondary beliefs, and therefore are easier to change. These types of policies are more likely to get support given the appropriate evidence and information.

New Public Management

Since the 1980s, the NPM has been the mainstream in the Public Administration literature. It has been applied in developed countries like New Zealand and the UK, and pushed into developing countries such as Mexico and Chile. This model argues for more decentralisation, greater involvement of the private sector in service delivery and the introduction of market mechanisms (like choice and competition) to increase quality and efficiency. Research findings in the Mexican case, however, suggest that decentralisation *per se* does not improve service delivery. Effective implementation entails extending access to services and, as this thesis suggests, policy implementation was seriously constrained due to clashes between federal and local health authorities. Decentralisation raises issues about relationships amongst different levels of government that the NPM does not take into account.

The focus on incentives and controls ignores the influence of ideas, values and beliefs on attitudes and opinions, and ultimately on behaviour. This is based on the basic assumption about the individual that has characterised the classic debate between politics and neoclassical economics. Are individuals motivated by a material self-interest, or are their preferences shaped by ideas and beliefs? There are strong arguments in favour and against, but little agreement. Findings of this thesis suggest that ideas, values and beliefs are central and should be taken into account when looking to change or motivate a desired behaviour. Even though the sides of this debate part from different essential assumptions, it would still be possible to test the extent to which material incentives and performance controls may influence implementers' behaviour. This could be the subject for future research.

Participatory democracy

Enhanced citizen participation and accountability mechanisms are central to the literature on participatory democracy. Research findings support these arguments but also raise some questions about them. This democracy model gives for granted the

willingness of citizens and CSOs to participate in policy process; however, the Mexican experience shows a very limited involvement of key civil society actors. Medical schools and medical professional organisations are not interested in engaging in public health policy. As a result, there is a weak alignment of medical education and professional organisations with public health policy. One consequence, as observed in this research, is the limited availability of medical staff willing to participate in public health policies, such as the ILE law. But the literature pays little attention to constraints or unwillingness to get involved in public policy processes. The historical background and other contextual factors should be taken into account when looking at civil society participation in both policy processes and societal accountability.

8.4 Policy recommendations

This thesis aimed to provide both politicians and service providers a study that could give some suggestions for future policy and decision-making. This section describes the most relevant lessons to be learnt from the experience in Mexico City. These policy recommendations may help to improve policy implementation of the policies analysed in this thesis, as well as other new or current policies either in Mexico or other countries.

Identify policy beliefs among implementers. For more effective policy implementation, the people involved in the process should share the core ideas that support the policy. Conflict of values and beliefs may be avoided if it is recognised before implementation actually starts. Ideas and beliefs may change with relevant evidence and arguments. It is important to understand what both management and street-level implementers think about the policy and their attitudes towards it. It is useful to know what to expect from them and the potential problems that may arise during the implementation process. By doing this, a strategic plan may be devised to avoid conflict.

Training and working with implementers. This research showed that staff training improves policy implementation. Having a better understanding of the policy and its procedures helps implementers to perform better. If there is a clash of staff and policy ideas, they may change their opinions and attitudes with appropriate training. It

is also useful to compensate for poor medical education or unfamiliarity with methods and techniques required to put the policy in practice.

Extend policy implementation to private and third sectors providers. Access to policy services expands with the participation of these sectors. Their participation may be motivated with appropriate incentives tailored to each kind of sector. The private sector is profit-driven and this should be taken into account. However, as research findings show, private health care providers can also be concerned with other non-material issues like reputation and prestige. In the case of third-sector providers, organisations that share the underlying ideas of the policy in question may be more interested in participating; hence, it would be easier to collaborate with them.

Introduce and strengthen managerial skills. Policy implementation may benefit from stronger managerial practices. These can improve administration of resources and procedures. They can also help in influencing staff behaviour if underlying values and beliefs are carefully understood. Appropriate incentives and procedures may avoid hostile work environments and worn-out staff.

Strengthen citizen participation. A greater involvement of civil society and individual citizens may improve policy implementation. CSOs, especially NGOs, can provide resources and expertise to public institutions.

Allow sanctions to hold service providers to account. Service providers should be held responsible for their (in)actions. Accountability mechanisms could be more effective if they sanction wrongdoings instead of only pointing them out or suggesting better practices.

Align medical education and training with public health policies. One of the major problems found in the implementation of the decriminalisation of abortion policy was the lack of medical practitioners willing to perform abortions in public hospitals. Medical schools were not providing the relevant training, nor fostering the values and beliefs that support this public health policy. Medical schools and public health policy must be aligned in order to avoid the unavailability of human resources. This is more evident in morality policies; however, it should be relevant to any type of health policy.

These policy recommendations are suggestions based on the findings of this thesis, but are not prescriptive. They should be taken as lessons learnt from the Mexican experience with the PHI policy and the ILE law.

8.5 Future research

The fragmentation of the Mexican health system is well-known; however, the implications of that fragmentation for health equality and health outcomes are unknown. Also, little is known about competition and choice in the Mexican context. It is important to know if the plurality of the health system allows patients to choose health care providers and, if there is competition, how it benefits patients. The involvement of private and third sectors in public service delivery benefits policy implementation. Given the lack of extensive studies about their role and participation in the overall health system in Mexico, more data and information on them would be very useful. More data about their practices, market shares, prices, and services, to mention some issues, are needed.

The Mexican health system highlights the importance of revising health system models in order to include the effects of globalisation. The internationalisation of health systems, especially the private and non-profit sub-systems, is still not fully addressed by the relevant literature. The Mexican case is an example of a phenomenon that is taking place in other developing countries, such as India and Thailand, where private health care providers are marketing their services to foreigners and attracting an increasing number of them. The implications of health-related tourism to national health systems are still unknown. In the case of legal abortion, this takes more significance since women may travel from one country to another in order to have the procedure, such as in the case of Ireland and UK. Another sign of globalisation is observed in the third sector. Many non-profit health providers in developing countries are partially or completely funded by international donors. In the case of Mexico City, the presence of NGOs with international support has a positive impact on extending access to services.

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Appendices

Appendix 1. Thematic guide for service providers' interviews

Appendix 2. Map of Federal District (Mexico City). Service providers interviewed.

Appendix 1. Thematic guide for service providers' interviews

⇒ Medical establishment characteristics:

- Number of acute beds available
- Medical staff
- Average patients per day
- Prices of main services

- Control mechanisms in place
- Performance incentives for staff
- Links with civil society organisations, community, citizens
- Relationships with local and federal government agencies
- Relationships with other service providers

⇒ Popular Health Insurance

- Do you think the PHI responds to the population's health care needs?
- Accreditation process of health unit
- Operation
 - Staff
 - Affiliation process
 - Resources – facilities, equipment
 - Administration and controls
- Difficulties and/or problems
- Changes in every-day work
- Perceived autonomy from PHI central coordination
- Training
- Staff response to SP
- Monitoring of activities
- Differences with Free health care programme
- Registering cases/patients

⇒ Termination of pregnancy

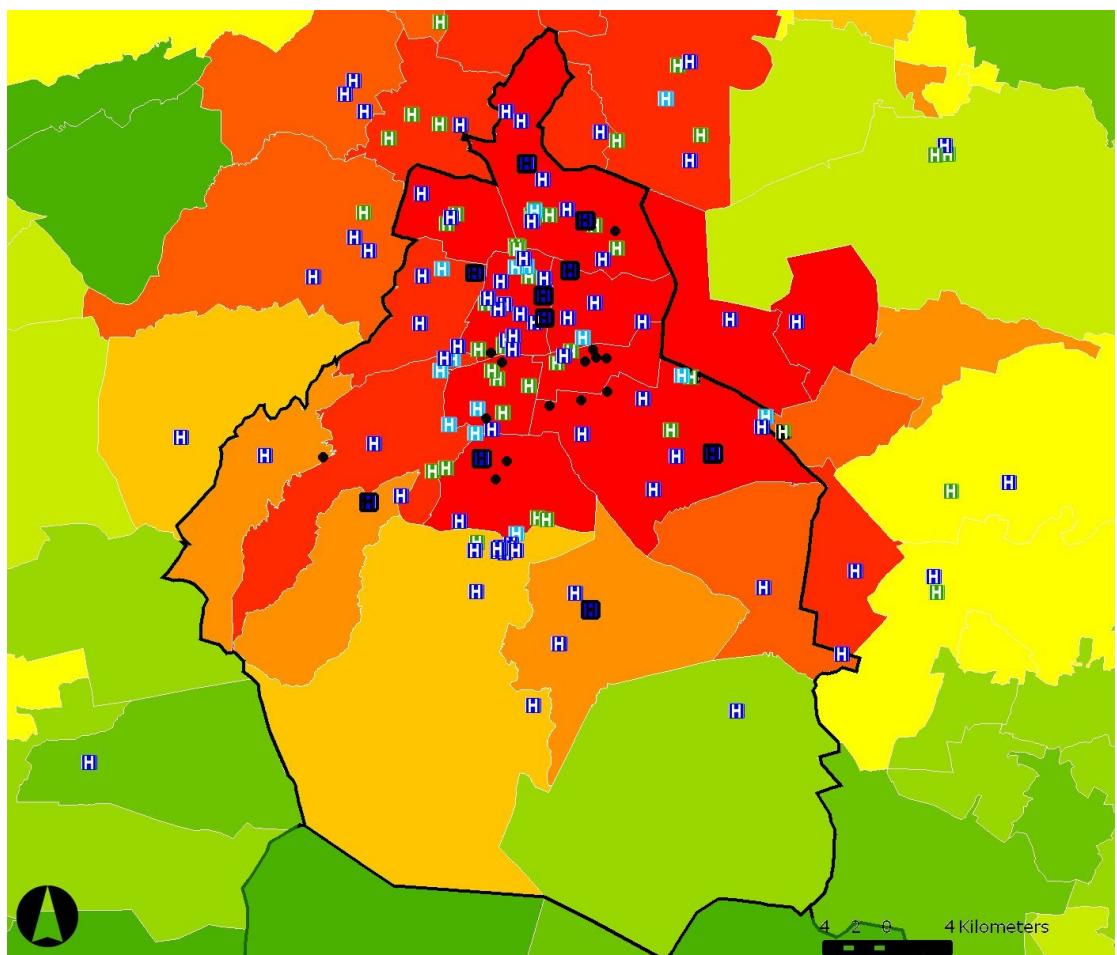
- Do you think that clandestine abortion is a public health issue?
- Do you think the ILE responds to that problem?
- Position on abortion
- Participation in public debate
- Staff response to ILE
- Conscientious objection and medical staff
- Hiring and quitting medical staff
- Difficulties and/or problems, conflicts
- Changes in every-day work
- Perceived autonomy from ILE central coordination
- Training
- Monitoring of activities and control mechanisms

- Resources – facilities, equipment
- Incentives
- Civil society, citizen participation

⇒ Personal information:

- Years in that post
- Other jobs – private or public sector
- Professional associations memberships
- Religion
- Political party preference

Appendix 2. Map of Federal District (Mexico City). Service providers interviewed.



Medical establishments (2nd and 3rd levels):

- SSA (all) – interviewed in black
- IMSS (all)
- ISSSTE (all)
- Private and non-profit (interviewed)

Population density (Hab/Km²):

0.12 - 51.34
51.35 - 127.52
127.53 - 245.00
245.01 - 431.04
431.05 - 775.69
775.70 - 1318.06
1318.07 - 2260.05
2260.06 - 3880.18
3880.19 - 6432.67
6432.68 - 10664.49
10664.50 - 18002.42

Source: NAAIS, Dirección de Informática y Geografía Médica
<http://sigsalud.insp.mx/naais/home.asp>