

**THE REORGANISATION OF THE MEXICAN HEALTH SYSTEM,
SEEN FROM A EUROPEAN PERSPECTIVE.**

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PAPER PRESENTED AT THE INTERNATIONAL WORKSHOP ON
The Transformation of Latin American Social Policy
– Dynamics, Institutions and Outcomes

7 November 2014

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In Latin America as well as in many other parts of the world, health care systems are facing a wide range of problems among which unaffordable insurance coverage and unequal access to (high quality) services. With health care provision being an important ingredient of social policy, the response to these problems is of utmost importance when studying the development of welfare states around the globe and also in Latin American countries. Internationally, health care policies have aimed at containing the financial burden emanating from growing health care needs and improved medical technology. Concomitantly, however, there has been an international trend towards creating (or completing) universal coverage and ensuring better quality in service provision. In both dimensions, *management reforms* have been viewed an essential precondition for achieving policy objectives; hence many health care systems has become subject to substantial reorganization.

Mexico has not been an exception here. The respective attempts can be traced back to the 1980s decade that saw movements of privatization and decentralization. In 2001, the country enacted a more encompassing health care reform establishing the so called ‘Popular Insurance’, a scheme meant to enhance the access to services for citizens working in the informal sector and not yet covered by formal social insurance. While this has been an important step for the modernization of the Mexican welfare state, this paper argues that the way this reform was implemented also caused functional limitations on the way to (a more) universal health care system. This experience has led the Mexican state administration strive for a ‘Universal National Health System’, with new modes of coordination meant to provide greater administrative integration (see below); yet as this new initiative is based on managerial approaches such as the outsourcing of services or differential performance evaluation, it may not resolve the most urgent problems.

Such dynamics are far from being confined to Mexico. Rather, a second argument put forward by this paper is that, by modeling administrative reforms on what has been developed for typical Western welfare regimes, this country follows an international trend towards *managerialist modernization* which, as a matter of principle, sets limits to the objective of extending and improving health care coverage both in quantitative and qualitative dimensions – although the extent and the dimension of such dynamics vary across these regimes.

We capture this variety by comparing the development in Mexico with the one in jurisdictions that are usually *not* seen as typical NPM countries according to the wider literature. Elucidating traces of ‘quasi-NPM’ reforms in two of such countries, *Norway* and *Germany*, we have to confine ourselves to the basic rationales of managerial reform in these countries as assessed by the wider literature. The countries are interesting also because one (Norway) exhibits a

formally high-integrated health care system while the other (Germany) has a long history of ‘organized pluralism’. We cannot offer a systematic comparison here but relate general movements observed in these two European jurisdictions to developments in a country that uses to be considered as being a transition state.¹ This endeavor brings to the fore that a country such as Mexico develops in line with a general international regulatory movement *more or less (widely)* connected to the NPM agenda, albeit in a more hybrid way and with contradictory regulatory developments (like in Norway and Germany). This movement, we argue, embraces steps taken towards benefit harmonization, on the one hand, and procedural disorganization on the other. The evolution in Mexico bears witness to a distinctive process of meta-institutional learning, based on these paradoxical regulatory concepts. Overall, we contend that one can gain a better understanding of developmental dynamics in a country like Mexico when exploring them through this analytical lens and relating them to international trends.

We will start by briefly reviewing dynamics of reorganization in health care systems from the perspective of public administration. Thereafter, following a short section on our methodology, developments in Mexico will be depicted in greater detail, with a focus on recent managerial reforms. The evidence will then be contrasted with observations from the two other countries mentioned above. The final section will provide a theoretical reading of the international agenda behind the current reorganization of health care systems, together with a short discussion of the impact this agenda may have in terms of timely social policy objectives.

1. Management reforms in public service provision: Issues in the wider debate

A widespread perception in the literature on public administration has been that ‘*governing*’ has become more and more complex including when it comes to the organization of basic human services (Rhodes, 1996; Jessop, 2002; Fenwick & McMillan, 2010). The much-used formula ‘from government to governance’ (Bellamy & Palumbo, 2010) has been the most prominent expression of this reading. The running of public services is viewed to involve ever more actors with ever more multifaceted patterns of information exchange, opinion-building,

¹ Insofar, our analysis borrows on what has become known as ‘most dissimilar systems design’ (Przeworski & Teune, 1979), following a qualitative approach to international comparison (Mangen, 2004; Mahony, 2007).

² It can certainly be argued that the movement from government to governance has had limits (Koch, 2013).

and steering (including across networks) so that the steering of the public sector appears more intricate than in past times (Keast et al., 2006).²

This observation chimes with a conjecture according to which public service provision in the modern world is affected by ‘*system integration problems*’. Yet in health care (like in many other areas of public service provision), integrated service delivery continues to be viewed as a precondition for enhancing (or at least preserving) access to decent care provision and for ensuring a high(er) level of service quality (Armitrage et al., 2009; Atun et al., 2010, Nolte et al., 2012). The challenge appears considerable, though. The health care infrastructure is composed of a multitude of activities, professions, administrative functions and organizational contexts. Moreover, the various collective actors tend to live their own life once they become established as distinctive organizational entities (Hannan & Freeman, 1984; Thornton et al., 2005; De La Luz Fernández-Alles & Rocío Llamas-Sánchez, 2008). In addition, institutional and organizational inertia often appear a natural feature of such configurations (Wilson, 1975; Genschel, 1997; Hämäläinen et al., 2012). Through the impact of diverging interests and institutional traditions, the interaction of the various parties tends to produce dissonance (Benson, 1975; Philipps et al., 2000), not least because of the interprofessional ‘clash of cultures’ (Pippa, 2005) typical of human service provision.

Against this backdrop, making sure that all citizens receive the same level of medical care – that is, an objective we will refer to as ‘benefit harmonization’ in the remainder of this paper – appears a ‘wicked problem’.³ Various *management reforms* around the globe have sought to solve this problem by radical institutional change. ‘New Public Management’ (NPM) has been the most influential concept for this over the last decades (although it has addressed further objectives as well). Far from being outmoded in current times (see Enthoven, 2012; Numerof & Abrahams, 2013), the NPM mantra has traveled cross-border and left hallmarks throughout very diverse health care systems (Pollitt & Bouckaert, 2011; Simonet, 2011).

One important element of NPM (when applied to health care) has been ‘*managed care*’ as a concept for harmonizing and streamlining service administration and provision. A central claim of this concept is that there be organizational units or agent that keep ‘everything under

² It can certainly be argued that the movement from government to governance has had limits (Koch, 2013). Also, across major Western societies, patterns of network-based state administration have existed long before the aforementioned ‘from-to-formula’ was invented (see e.g. Bode 2010). Nonetheless, one can hardly deny that, nowadays, public service provision is more multifaceted than during the post-war era.

³ In their well-known definition, Rittel & Webber (1973), studying the intricacies of social planning, have referred to such problems as configurations in which problem-solving knowledge proves scarce, where objectives are plural, and in which the nature of a given problematic (the relationship between cause and effect) appears fuzzy (ibid: 160). Up to our days, health care bodies engaged with institutional collaboration confront such fuzziness over and over again (Ferlie et al., 2011).

control'. Service provision based on uniform products, prices, incentives and sanctions, furthermore the creation of one-stop agencies, administrative decentralization under top-down monitoring, standardized accountability schemes, and steering based on rigid output evaluation are all been part of the tool-kit used for ensuring such control.

Yet NPM-led reforms have also established a separation of previously interrelated roles sets and task structures. Contemporary public sector 'managerialism' (Clarke & Newman, 1997; Barberis, 2013) is geared towards steering service provision by creating intraorganisational divisions *within* the responsible agencies (such as pay for performance, profit centers, or 'internal customer' models). As for *inter*-organizational relationships, moreover, it involves a multiplication of agencies and contractual processes (Clarke & Newman, 1997; Osborne, 2006; Goldfinch, 2009; Culebro, 2008; Culebro & Arellano Gault, 2012). In many cases, inter-agency coordination has been reorganized by introducing market mechanisms, creating permanent competitive pressures and economic risks for individual providers and agents (Walker et al, 2011; Verspohl, 2012).

All this is prone to entail an ever more *disorganized infrastructure* of public service provision in many places. In the context of welfare state administration, the term disorganization refers to processes of developing, steering, resourcing and monitoring public service provision and may manifest itself in fluctuations of a provider's income or contractual involvement on the one hand, disruption and volatility in the process (or quality) of service provision, on the other (see Bode, 2003 and 2010). Seen from this angle, NPM, though being geared towards ensuring greater uniformity, has a potential to create additional problems for 'system integration'.

The regulatory complexity of these new institutional arrangements has led Governments (in some countries) to rethink or enrich the reform agenda after the 'golden era' of NPM.⁴ Thus, the recourse to collective deliberation and joined-up-government in some countries has been viewed to be indicative of a '*post-NPM*' configuration taking centre stage (Bogdanor, 2005). It has been observed furthermore that management structures exhibiting decentralized responsibilities and local entrepreneurialism have partially been reverted into patterns of more centralized coordination and oversight. However, following Christensen and Laegreid (2011), the patterns established under NPM have become overlayed, rather than replaced, by such measures, with the result being even more regulatory complexity.

⁴ Some scholars have even argued that the experience of such complexity has 'killed' the NPM-agenda (Fenwick & McMillan, 2010). Yet how far it makes sense to speak of a 'post-NPM' agenda in which the key elements of the NPM-model are superseded by new approaches is an empirical question after all (for a more skeptical view, see Koch 2013).

De-constructing this intricate configuration remains a key challenge to both social policy analysis and public administration research. Concerning medical services, marrying contemporary public sector management with policies meant to ensure benefit harmonization obviously remains a delicate undertaking, in particular where a modern health care system is still in the making and the aforementioned paradoxical tendencies can be observed. But which dynamics shape the respective development in the special context of Latin America? And how can we understand them from a European perspective and in relation to the theoretical considerations reviewed in this section? The following analysis will show that the reorganization of health care systems in a transition state such as Mexico is an expression of institutional change rooted in an international agenda through which management reforms instill contradictory regulatory logics into health care systems, with an inconsistent social policy design as an unavoidable result.

2. The reorganization of health care in Mexico

In what follows, we scrutinize recent regulatory developments in the Mexican health care system with a focus on both management reforms and the afore-sketched ‘system integration problem’. Our analysis covers a period of approximately three decades, in which the most important reforms have taken place. In terms of *methodology*, it is based on various data among which expert interviews with key informants from the sector: These include members of one central board of the National Commission of the Popular Insurance Scheme (the CNPSS, see below) and from federal and local government (State Popular Insurance Scheme, REPSS).⁵ In addition, we draw on a review of public and organizational documents (such as official guidelines) as well of the evolving legislation concerning the Mexican health care system. This material was exploited by using directive content analysis (Hsieh & Shannon, 2005), based on some general categories such as: the nature and development of the organizations involved in health care regulation, prevailing governance arrangements including for the coordination between the various units of the health care systems, and actual relationships within and between these units. The overarching analytical perspective consisted of assessing the ‘case logic’ (Yin, 2009) regarding the development in the Mexican health care system.

⁵ This part of the paper derives from a larger research project (Mexico City), dealing with the impact of NPM on processes of regulation and on the institutional design of regulatory agencies in the sector.

General characteristics of the Mexican health care system

Since the early twentieth century, Mexico's welfare state exhibits a segmented and fragmented character, similar to what can be observed in other parts of Latin America. On the one hand, there are institutions for citizens in formal employment – whether in the public sector (at the Federal or State level) or in private business (about half of the population); and, on the other, those for the unemployed and in the informal economy. Health care provision has remained very unequal across regions as well. The system exhibits poor quality and strong inequality in access to services, especially for those not enrolled in a social security scheme (see Frenk et al., 2009; Chertorivski et al., 2012).⁶ Regarding service provision, primary care is underdeveloped while inpatient services are more widespread but small-scale; specialized services (at tertiary level) are available for insured patients in the first instance and generally acceptable quality. Still in our days, the various pillars each have an administrative structure of their own.

Table 1. The social security scheme in Mexico.

Financing	Tripartite. Federal government, taxes. Employers payroll contributions. Employees.
Infrastructure	IMSS Federal state (ISSSTE) special companies (Pemex,) armed forces
Delivery	Hospitals and clinics owned by these social security organizations (IMSS, ISSSTE, etc.)
Beneficiaries	Workers in the formal economy State employees (for both:) families and retirees
Entitlements	Access to all medical services (plus pensions, maternity benefits etc.)
Areas where NPM comes into play	Outsourcing and use of 'modern' managerial techniques (such as performance evaluation schemes; accounting based on product prices)

The regulatory framework is very complex and contains a large variety of organizational entities. Its *administrative architecture* is composed of three large, vertically integrated pillars (with two of them being of the same type). The first pillar mainly embraces two components that do not overlap, neither practically nor financially although are meant to protect the so-called *derecho-habiente* (the legally entitled). These Social Security institutions comprise a number of different schemes – mainly the ISSSTE for federal state employees and the IMSS

⁶ The resource base of health care in terms of personnel and service units is very weak in comparison to other OECD countries; it is used for the day-to-day running of the system rather than for investment. Salaries for the medical staff are low if compared to the private industry sector. According to the OECD, out-of-pocket spending is considerable (45% of total health care expenditure); also, pre-payments are highly developed including for wealthy patients.

for private sector workers –, and a set of agencies under the control of the Secretary of Health (labeled SS).⁷ Besides, each State has its own social security scheme for public employees. Enrolment in these insurance schemes is mandatory for salaried workers. As for funding, the IMSSS and ISSSTE schemes receive contributions from workers, employers, and Government. By tradition, these key institutions run their own infrastructure service provision (clinics and hospitals of all levels). Most offer a wider range of services for the enrollees themselves, further for their families and for retirees (who receive not only health care from these pillars but also other benefits such as pensions and family benefits).

The second big pillar in the current Mexican health care system is the so called 'popular insurance' scheme (*Seguro popular*, SP). It is funded primarily by federal taxes although symbolic contributions of enrollees add to this.⁸ For various reasons, the establishment of the scheme can be considered an expression of NPM pervading the welfare state in Mexico. As for entitlements, the scheme resembles private insurance in that it offers a pre-calculated service package, based on a 'capped' list of benefits (see below); in this respect, it is very different from a universal health care model. Moreover, within the scheme, for the first time in Mexico, service provision is operated by different categories of organizations under the roof of an autonomous entity located at the administrative level of the States, called REPSS⁹.

Table 2. The popular insurance scheme.

Funding	Tax/Federal State subsidies, family contribution; user fees
Infrastructure	CNPSS MH / state health REPSS
Delivery	Hospitals / clinics of the States, Secretary of health (with some outsourcing to private sector providers)
Beneficiaries	Informal, unemployed, self-employed, poor citizens (including those benefiting from welfare programs)
Entitlements	like private insurance, covering a list of disorders.
Areas where NPM comes into play	Organizational separation of funding and delivery.

The creation of the new pillar *as such* has consolidated the scattered character of the Mexican health care system. It serves as (porous) safety net for those without social insurance coverage (about half of the population) for a distinct category of citizens (those from the informal economy), with special health care units under the control of the Secretary of Health (including at state level), instead of social security institutions. An essential steering tool for the SP is

⁷ In the social security pillar, health care units are part of a larger set of social welfare services, providing, among other things, child care and maternity benefits. This is not the case with the SPSS.

⁸ De facto, the income of the SP is also tripartite, composed of a 'social fee' from the federal government, a subsidy from the states, and a small 'family contribution' which is voluntary.

⁹ Regímenes Estatales de Protección Social en Salud.

a list of diseases for which treatments are guaranteed (CNPSS, 2010); the range of illnesses covered by this list (called CAUSES) is limited, so are funds earmarked for financing service provision. It is noteworthy that the popular insurance is linked to further social programs (such as PROGRESA and IMSS opportunities) which address families who live in extreme poverty. This contributes to the 'selective targeting approach' of the second pillar.

The third pillar is the private sector that has become more important recently, also because it has begun to provide services for beneficiaries covered by the Social Security institutions and even by SP, with this being based on procurement contracts. This pillar is operated by private insurance companies; providers receive direct payments from users or reimbursements from these companies. Private insurance companies are rather flexible and diverse concerning the type of coverage they offer. Usually, enrollees have a high income and have sophisticated service facilities at their disposal. Public regulation appears rather weak here (OECD, 2005).

Table 3. The private pillar.

Funding	Individuals out of pocket, employers
Infrastructure	Private insurances companies.
Delivery	Private hospitals and clinics, Physicians charging fees for service
Beneficiaries	Citizens with high income, in some cases average workers benefiting from company enrolment
Entitlements	Health services as established in the letter of coverage

Concerning the *steering of the overall health care system*, public oversight is shared between the federal and state level, although the coordination of system is under the responsibility of the Federal Secretary of Health, with the highest regulatory authority being the so-called General Health Council. The Federal Secretary orchestrates the decentralized administration of the system through instruments such as the National Health Program (based on provisions of the 'General Health Care Act'). The legal framework concerning service supply and sanitary conditions, as well as for risk prevention, is equally federal in kind and feeds into activities of national regulatory agencies.

However, the day-to-day organization of the system appears dispersed overall. Diverse regulatory and financial frameworks coexist, including the IMSS/ISSSTE scheme and those units under the SP program that are responsible for citizens without social security coverage and which operate under the oversight of the CNPSS (see table 1). One of the most relevant coordination instruments of the popular insurance scheme (SP) are the annual agreements with the States to instruct the REPSS (see above). These agreements include a set of obligations and incentives for regional governments that affect the use of the federal funds (for paying pro-

viders), as well as mechanisms ensuring federal control. Providers in the public pillar – that is: public hospitals and clinics involved in the provision of primary care – have little autonomy; a great deal of resource management concerns the payment of staff (OECD, 2005).¹⁰ The regional level plays a more important role when it comes to service provision. Special contracts or agreements are passed between federal and regional authorities, particularly regarding the distribution of financial resources. On the whole, a clear-cut and unitary rationale for steering the system has never emerged – which also implies that NPM has not played the role of an *official template* for management reform, unlike in some other parts of the world. As we shall see, however, major elements of it do have inspired reform movements in Mexico over the last decade.

Reforms and developments in regulation.

Since the establishment of the Secretary of Health and Assistance (1943), there has been an enduring tension between two regulatory models: social assistance and social security.¹¹ Although the idea of ‘social security for all’ was prevailing conceptually, the two models have persisted and led into a scattered system featuring strong vertical and horizontal divisions, as well as some degree of decentralization (Homedes & Ugalde, 2005). Over the last decades, this system has seen a number of transformations, motivated by both internal and external pressures. Internally, it has been challenged by a growing demand for better services. Regarding external influences, there has been a tendency to resort to NPM concepts propagated by international organizations.

From the 1980s onwards, various policies have been inspired by these concepts. An early reform, aimed at expanding coverage and improving the quality of service provision, brought a first wave of decentralization, with the Secretary Health and Assistance being renamed into Secretary of Health. A second wave of regulatory innovation occurred during the 1990s, in a context of social welfare programs for poverty alleviation. During the first decade of the new century, further initiatives were taken. A reform enacted between 2002 and 2006 introduced the so-called Integrated Model of Health Care (MIDAS), with the Undersecretary of Innovation and Quality of the Secretary of Health made responsible for its implementation; an additional set of measures was meant to improve the functional integration of the various actors

¹⁰ Based on global budgets, each public health care institution manages its own assets and personnel.

¹¹ A first ambitious reform was passed in the late 1970s when the model of hospital care began to reach its limits. It saw efforts to bring health services to rural areas and poor communities, with the creation of the national Institute of Public Health and steps taken to ensure a more fine-grained assessment of public policy impact in the health sector (Frenk et al 2003).

within the health care system, this time under the control of the Undersecretary of Integration and Development of the Health Sector (Perez-Hernandez et al, 2013). However, the most important reform initiative was taken at the beginning of the new millennium, with the establishment of the aforementioned SPSS and its operating arm, the CNPSS (in 2004).¹² This initiative, implemented in several steps, was geared towards guaranteeing universal protection to the then not-insured population and was boosted by special funding. It was to serve several objectives (FMS 2005, SS.CNPSS, 2006; Gobierno Federal, 2007; Jaramillo 2007): diminishing the number of families impoverished when facing extremely high health care expenditure (González Pier et al., 2006: 27); creating a ‘culture of prepayment’ among beneficiaries; and changing the administrative arrangements relevant to this branch of the health care system.¹³

The establishment of the SP took place by experimental learning, firstly with assistance from international organizations like the World Bank and the through pilot programs. Importantly, the reforms brought coordination mechanisms rooted in the NPM orthodoxy. These include, first of all, formalized annual agreements between the Federal level and the States. Secondly, the strengthening of horizontal and vertical specialization as well as the devolution of responsibilities to the States proved central ingredients of the reform. Furthermore, a range of single purpose agencies was created, with each holding a distinctive responsibility – either for regulatory functions, like in the case of the so-called COFEPRIS, or for financial management, like in the case of the CNPSS. Further regulatory bodies add to this: the COFEPRIS which holds a mission of preventing sanitary risks but exhibits weak regulatory capacity (OECD, 2005), and the so-called CONAMED – which is a body meant to resolve conflicts among patients and doctors in the system. There also exists a commission concerned with bioethical issues (called CNB). Regulatory functions have been devolved upon separate entities: the Federal Secretary of Health¹⁴, central public authority, furthermore the COFEPRIS, and finally the CNPSS and the provider institutions.

Perhaps most important feature of these reforms has been – thirdly – the split-up of the administrative set-up for the (previously) non-insured population. By separating purchasing and providing functions, a dual identity was conferred upon public administration. Nowadays, the

¹² resulting from a set of amendments to the ‘General Health Care Act’

¹³ The official motivation were imbalances in the health care system due to the low level of overall expenditure, the predominance of out-of-pocket payment and the inequity between the insured population and the non-insured (Frenk et al 2006: 1526).

¹⁴ The implementation of the SP was also meant to ease financial pressures caused by both the evolving age pyramid of the Mexican population and epidemiologic developments (González Pier et al. 2006). Experts have bemoaned however that there still are incentives for avoiding an enrolment in the scheme (Levy, 2008).

CNPSS operates as a funding agency managing the ‘Popular insurance’ (SP) centrally whereas institutions of the States – the REPSS – have a remit for contracting health care suppliers locally. The REPSS, responsible for organizing services and developing capacity at local level, are meant to involve public and private actors *across sectors* – in that sense, they become boundary-spanning agencies expected to manage relations with ‘foreign’ co-actors (such as private or Social Security organizations) of which the outcome is left to the open-ended interplay of those involved.

Open contracting and performance management, a typical NPM steering instrument, has been put on the rails as well. While, thus far, this process seems stumbling in many places, there are some cases where it has been rolled out effectively, e.g. in the State of Jalisco (Arellano et al, 2012). Moreover, the agencies from the different pillars have begun to resort to internal management tools for output evaluation and for performance-based payment (Soberón-Acevedo & Valdés-Olmedo, 2007). Entrepreneurial managerialism seems to take centre stage here. While contracts have become a typical steering instrument, their monitoring got struck in many places. Thus, the CNPSS suffers from weak institutional capacity when it comes to put sanctions on single REPSS failing to meet the agreed objectives. Furthermore, there are growing tensions between the controls required by the CNPSS, eager to fulfill the goals of the SPSS, and the autonomy claimed by both the REPSS and State health authorities when dealing with population health and innovations (Arellano et al, 2011; 2012).

Overall, with a differentiation of the functions of finance, insurance, management and service delivery, the health care system becomes disorganized. The current regulatory system turns out to be a complex network of institutions and agencies operating at various levels and with different powers and responsibilities. This is stark contrast with the fact that the reforms have been aimed at entailing the harmonization of benefits and at improving coordination¹⁵ both horizontally among similar organizations and vertically across different levels of government, together with managerial techniques to ensure a more straightforward administration of the public resources invested.

A new round of reform: Towards a ‘real’ universal health care system?

Despite the many changes in the Mexican health system, the latter still appears overly fragmented and poorly coordinated. This has a wider impact on the social situation in the country, including with an eye on the development of employment, pensions, and education, since the

¹⁵ Not least by drafting a ‘General Health Care Act’ (in the 1990s).

afore-sketched segmentation leads to deficient health services and reduces the competitiveness of the economy (Ibarra et al 2012). The system suffers from an excessive duplication of administrative functions, a lack of accountability instruments, and weak inter-agency coordination. The present government seems to react to this situation by proposing the creation of a national system of universal health. Four strategies have been developed for this purpose: the first is to establish institutional mechanisms that provide the foundation of this universal system, the second consists of strengthening regulation within the health sector, the third is to improve the instruments for the monitoring, evaluation and transparency of health care organizations, and the fourth is to unify health care information (Secretary of Health, Sectoral Program).

In some way, this proposal departs from the regulatory concept underlying the popular insurance scheme (SP). The idea is to establish, under the control of the federal government, a set of incentives that are geared towards the incorporation of wider sections of the population in the formal social security pillar, on the one hand, and social welfare programs such as OPORTUNIDADES, on the other – with all this being orchestrated by the Ministry of Finance. It is intended to generate new institutional mechanisms for both coordinating health care institutions and managing service provision. Regulatory mechanisms shall become centralized and concentrated in a single regulatory agency at the level of the Ministry of Health, while a national system of evaluation and performance evaluation (centering on health professionals and using ICT-data from beneficiaries) shall enhance accountability. Thus, the reform seeks to replace vertical integration by a horizontal organization in which stewardship lies with the Secretary of federal health and the financing is operated through a single fund supplied with tax revenue rather than contributions from employers and government (FUNSALUD 2013).

Organizationally speaking, the idea is to further split up financing and service delivery. Health is to be provided in a network of public and private institutions, with enhanced options to exchange responsibilities for service delivery among private and public institutions. The funding may come from specific funds or from general taxation. As for the coordination of the new system, two mechanisms are given particular emphasis: the first is that the Secretary of Health and the Ministry of Finance holds a supremacy in providing incentives and establishing the operational schemes; a second intention is to concentrate regulation and control at the federal level in one entity, which reminds of concepts such as Joint United Government (JUG) and the Whole of Government Approach (WOG).

It remains to be seen whether this reform plan will bear fruits. In any case, it reflects a willingness to take yet another step towards greater integration including at the regulatory level. However, basic features of the current model are maintained or even made more influential: This especially concerns the ‘disorganized’ character of the existing infrastructure for service delivery as the reform is geared towards the establishment of flexible and potentially volatile contractualisation affecting entities that each hold a distinctive administrative status and that would carry the economic risk individually when it comes to ensuring service delivery. In this sense, the NPM orthodoxy seems to become stronger than ever before.

3. The evidence in the light of management reforms in European health care systems

As noted earlier, European health care systems have been strongly affected by management reforms over the last decades (for many: Pavolini and Guillén, 2013). Compared to Mexico, these ‘mature’ systems have been viewed to be inefficient and costly while concerns concerning equity and access to services have played a minor role. And still, it has been bemoaned in many places that patients do not receive what is possible in terms of *quality*, including with respect to their subjective needs. Hence there have been attempts to establish management schemes expected to provide both greater choice (to meet subjective needs) and a better control of service quality across sectors, agents and organizations. In that precise sense, European health care systems have seen further steps towards *benefit harmonization*.

At the same time, an interest in cost containment (particularly in the South of Europe) and a concern for cost-efficiency have been driving forces behind recent reforms. Overall, this multi-tiered reform agenda was largely inspired by the NPM mantra, featuring – among other things – a purchaser-provider split, fine-grained contractual regimes within and among organizational units, and differential payment according to economic success and measured performance, that is, a tendency to ‘*disorganize*’ institutional arrangements for public service provision and new forms of regulation.

The agenda has been very salient in countries with both a national health service and strong neoliberal forces. Particularly prominent in Anglo-Saxon societies, it has also extended to some other jurisdictions such as the Netherlands and Sweden. In ‘NPM countries’, the impetus to reorganize the health care system according to the NPM template has been strong since the early 1990s although reiterated attempts to implement these templates have brought about diffuse configurations in which this impetus – while being enforced institutionally – did not

fully pervade the system (for the case of England, see e.g. Patum, 2014, or Powell & Miller, 2014). That said, it is interesting to see how management reforms have been rolled out in developed countries where NPM has been much less influential *as a regulatory concepts* but have nonetheless left their traces (like in Mexico).

Norway

In the institutional set-up of the Norwegian welfare state, the public sector is powerful and strongly developed although the regional and the municipal level enjoy a great level of autonomy¹⁶, and despite the fact that social security has been in charge of various ministries and state organizations at various levels, with relatively little coordination between these levels (Christensen and Laegreid, 2002; 2010). The *health care sector*, is, at least from a bird's eye view, under strong national oversight, with a hierarchical line running through two ministries – the Ministry of Labor and the Ministry of Health. Both the administration of the system and the general rules for service delivery are embedded in a unitary framework. Medical care is very comprehensive, with universal coverage and protection against of any kind of disorder.¹⁷ However, technically speaking, the provision of services is incumbent on (more or less) decentralised agencies. By tradition, municipalities are responsible for primary care (in accordance with the Municipal Health Care Act from 1984) and are the first contact point for patients.¹⁸ Concerning the organization of services, municipalities are fairly heterogeneous; some of them spend up to 25% of their budget on health. The hospital sector, in charge of specialized medicine and mainly financed by government grants, has always been organized as sector apart from primary care. The relationship between the two sectors is viewed problematic, because they are located at different territorial levels and since each sector receives different types of funding linked to distinctive schemes for performance evaluation (Romeren et al., 2009).

Over the last decades, the health care system in Norway has experienced two major reform processes that shape its current structure and functioning. The first reform in particular can be

¹⁶ Norway is a relatively young, small and still fairly homogeneous nation in which collectivist and egalitarian values are widespread. This comes alongside one of the highest in per capita income in the world. Population is about 5 million inhabitants spread over an area of 385 199 km². As for the political system, Norway is a unitary state with a parliamentary system (symbolically embedded in a constitutional monarchy). Administratively and territorially speaking, the system consists of three levels, the national with 16 Ministries and national agencies, the regional composed by 19 counties and the local level with 429 municipalities.

¹⁷ It is one of the countries with the highest health care spending per capita (Romeren et al., 2011).

¹⁸ Primary care is mainly based on a general practitioner scheme that not only regulates funding but also the access to services through patient lists (patients can however change the assigned physician).

considered as having planted the seeds of NPM. However, contrary to the NPM orthodoxy that promotes decentralization, this reform basically consisted of restructuring the hospital sector through mergers. A key idea was to transfer property to the central state and at the same time to ensure a decentralized way of management (Laegreid et al, 2011). Concomitantly, the reforms were geared towards extending coverage and investing in public health, along with a more focused approach to patients. To accomplish this, the state was keen to devolve responsibilities on regional hospitals and to monitor activities by management tools such as performance evaluation schemes (Brykflot, 2005; Tjerbo, 2009). On the one hand, it was oriented towards enhancing formal coordination and ensuring a more homogeneous access to services (despite regional differences), and on the other hand, it was aimed at removing political influences from the management of health care provision in order to make the latter more efficient. A key instrument was a separation between politics and administration so as to isolate organizational decision making from politicians. It was also expected that this reduced conflicts between different levels of government.

Inpatient care was the most targeted sector. Decisions and operations of hospitals were now to be carried out by professional managers. According to Tjerbo (2009), two reform elements proved particularly crucial. Hospitals were reorganized as trusts or enterprises modelled on private sector companies as far as internal governance is concerned. They were equipped with a management board that became responsible for their own ‘business’ including strategic planning and should be subject to systematic performance evaluation based on numbers. The sector was divided in five regional areas, each overseen by health authorities enjoying some autonomy and institutional independence from central government. In the politico-administrative sphere, boards were created with members from all societal sectors, so as to create a public-private regulatory hybrid. Accordingly, the hospital reform enhanced the division of labor and the degree of specialization within the system, with this implying a trade-off between control and autonomy (Laegreid et al, 2005, Laegreid et al, 2011). At management level, techniques borrowed from private business (e.g. contracts establishing performance indicators as a basis for reports to the Ministry) were introduced, with this indirectly creating (symbolic) competition both between providers and within provider organizations.

The second major reform to be mentioned is the so-called reform of coordination.¹⁹ It sought to improve collaboration among the various health care units in order to provide more coher-

¹⁹ The official motivation behind this initiative was a concern “that there is too little initiative aimed at limiting and preventing disease” and worries concerning “the changing range of illnesses among the population” (Norwegian Ministry of Health and Social Services, 2009).

ent services to patients. Greater power was given to municipalities as key actors for primary care.²⁰ Moreover, all health care providers were to take over clear-cut responsibilities, combined with distinctive financial incentives. The reform placed the emphasis on greater horizontal and vertical communication, and on systematic relationship building among the involved organizations (Tjora, 2012). Overall, the diverse actors with their different professional and organizational logics were expected to increase the quality of service by collaborating in more formalized contexts.

The two reforms were meant to react on the (partial) fragmentation of health care provision in Norway. They were aimed at making all patients benefit from high performance by improving activities of prevention and a concern for demographic change. At the same time, the reorganization of the latter was aimed at making it more cost-efficient by discarding (allegedly) detrimental political influences and ambiguity in the distribution of steering roles. The instruments used for meeting the objectives brought both disorganization and – later on – new steps towards formalized coordination. There was some centralization (with planning processes at central level), yet instead of a more hierarchical administration, many regulatory functions were decentralized via a set of agreements between different levels of government. In addition, both the emphasis on entrepreneurial agency at provider level and management methods borrowed from private business indicate that the NPM rationale did have a certain influence in Norway – before triggering a strong impulsion towards reintegration with the aim to streamline the quality of the services provided.

Germany

Compared to Mexico, health care in Germany is the highly developed (as well).²¹ However, it exhibits characteristics that are different from both its Norwegian counterpart (see Table 4). The system embraces a strong outpatient sector with free-standing general practitioners and specialists while hospitals have (almost) no primary care role. Concerning the latter, there are strong institutional divisions as regards ownership and corporate governance.²² Hence, alt-

²⁰ Municipalities adopted a new role as they became more focused on co-financing the patients' treatment. For this, a number of economic incentives for coordination were established, as well as new forms of monitoring and evaluation by results.

²¹ OECD data for 2011 show the difference between Mexico and Germany: Expenses for health care amount to 6.2% of GDP (roughly 1.000 US \$) in Mexico and 11.6% in Germany (4.000 US \$). The most important contrast is 'out of pocket' funding: 47 % in the Latin American country and 13% in the German case.

²² Municipal, nonprofit and commercial providers hold equal shares of the sector.

though the bulk of health care providers offer services reimbursed by Social Security (and the two further schemes), there is considerable institutional pluralism on the supply side.

Table 4: Key institutions of the administration of the German health care system

<i>Level of organization</i>	<i>Institution</i>	<i>Funding</i>	<i>Addressees</i>
Federal State & States	Ministry of Health; agencies of the States	Public (private co-payment)	civil servants
Intermediate, quasi-public ('corporatist') bodies	nonprofit sickness funds (' <i>Krankenkassen</i> ', with national umbrella)	public and population (payroll contributions & private co-payment)	enrollees (employees) (various schemes)
Private sector	commercial insurance companies	private	wealthy citizens & self-employed (potential alternative to insurance with one of the sickness funds)

As regards the *administrative architecture* of the system, Social Security covers nine out of ten citizens, besides a periphery embracing the private insurance sector (mostly for wealthy people) and a civil servant regime run (primarily) by the States (*Länder*).²³ The 130 sickness funds (*Krankenkassen*) that are funded by pay-roll contributions serve as the operational arm of Social Security. The funds that operate under extensive public regulation are managed by representatives of the enrollees (and their employers in many cases). Holding a nonprofit status, they compete for enrollees and enjoy some leeway regarding administrative processes as well as the array of services they reimburse (Bode, 2010). There are slight differences in coverage, with advantages for those enrolled in the more prosperous sickness funds (pertaining to the entitlements to therapeutic aids, for instance). Notably, sickness funds in economic trouble may charge enrollees with higher contribution rates; those who fare well may refund a small proportion of contributions to enrollees.²⁴

Concerning *administrative arrangements*, the German health care system is outstanding internationally for having established a multi-partite 'institutional infrastructure' (Bode, 2013), with intermediate regulatory bodies located between the state and associations of the provid-

²³ In this sense, there is institutional pluralism as well (Thomson & Mossialos, 2006) – although the latter two schemes cover only 10% of the population (and will therefore be neglected in what follows). It should be mentioned that members of these schemes enjoy some privileges, for instance regarding the convenience and the timing of treatments. Enrollees of Social Security can contract additional private insurance, with the sickness funds often operating as brokers. They then enjoy more comfortable treatment in hospitals (special attention by chief physicians, for instance).

²⁴ Note that all patients incur (capped) co-payments fixed by Law.

ers. The aforementioned national umbrella of the sickness funds has a remit for clarifying norms and processes as defined by Social Law. It also participates in administrative bodies in which regulatory measures are agreed with federations of providers.²⁵ One of these bodies is the Federal Joint Committee (*Gemeinsamer Bundesausschuss*), a horizontal ‘integration agency’ embracing purchasers, providers, and representatives of user organizations (the latter only with a deliberative voice).²⁶ Hence collaborative self-administration within a pluralistic landscape of organizational entities is a typical feature of the German welfare state.

Concerning health care, horizontal deliberation is crucial. A typical example for this is agreements in the field of quality assurance (see below). However, by tradition, coordination is also processed vertically, via ‘hard contracts’. Doctors holding a free-standing private clinic are bound to collective agreements with the sickness funds (as payers); basically, these agreements fix a fee per service scheme.²⁷ While major regulatory frameworks of inpatient care are subject to provisions fixed by the State or agreed in the aforementioned ‘institutional infrastructure’, the resourcing of hospitals is fixed locally, through case-per-case bargaining involving a single hospital and the most important sickness funds. With reforms enacted in the beginning of the 2000s, agreements define a budget based on evidenced outputs in terms of number and types of disorders treated (according to a scheme of ‘diagnostic-related groups’, DRG, see below).

On the demand side, Germany has recently seen a further step towards benefit harmonization as the enrolment with health care insurance has become mandatory for all citizens, including the self-employed who only have access to private insurance (in this case, companies have to offer a basic tariff with standard coverage). This quasi-universal health insurance coverage can be seen as an integrative element of ‘social citizenship’ in the contemporary German welfare state (Bode, 2012). Moreover, recent years have seen a growing interest among German experts in improving cross-sector collaboration throughout the health care system so to make all patients benefit from high-quality services.²⁸ Steps were taken to extend the remit of the aforementioned ‘institutional infrastructure’, with quality assurance being a major topic here

²⁵ Further, though less powerful, instances of this kind can be found at the regional level, where hospital planning is located (among other things).

²⁶ In day-to-day regulation, the Ministry of Health is more of a veto player; it usually agrees health care policies with mayor stakeholders from the sector

²⁷ Similar provisions apply to other outpatient service providers (therapeutic aids, physiotherapists and the like).

²⁸ Thus, in 2009, a report of the most important advisory committee (*Sachverständigenrat*) of the German government, titled ‘*Koordination und Integration*’ (SVR, 2009) pointed at problems of fragmentation and redundancy in service supply.

(Sauerland, 2009). Health care outcomes were meant to become more uniform across populations of patients by benchmarking outcomes across providers and sectors.²⁹

However, the last two decades have also seen a tendency to strengthen market-oriented forms of administration throughout the health care system. Outpatient doctors have always been more or less free in deciding where to open their practice; hence there was provider competition in this sector. Activities and income issues however have been subject to collective contracts, and an association of doctors with mandatory membership has a remit of distributing the income package agreed with the sickness funds. Yet for some time now, selective contracts have been introduced for projects ('joint ventures') seeking to establish a formalized collaboration of providers around a given (group of) patients, akin to what is known from HMO in the U.S.³⁰ In this project, medical care arrangements become unique and differ from those existing elsewhere. In this sense, the new regulations addressing outpatient care follow 'managed care' logic (Nolte et al., 2012);³¹ hence, a NPM-inspired regulatory approach becomes discernable in the German health care system, with a more disorganized infrastructure for service provision as a consequence (Moosbach, 2009).

The same applies to developments in hospital care. According to reforms enacted in the early 2000s, the sickness funds pay uniform prices to suppliers which incur the full economic risk from the demand side (Bode, 2013). Providers depend on actual demand and fare differently according to local (market) situations. As they operate as autonomous economic entities (public, nonprofit, for-profit), and given that public planning on the supply side has become rudimentary, hospitals compete for patients and have to develop (or preserve) a market e.g. by cultivating links to outpatient doctors. As in the aforementioned areas, this is amenable to a more disorganized infrastructure of service provision, with systematic differentiation between production sites as an inevitable consequence.

A more recent reform plan is the introduction of pay-for-performance (P4P) schemes, meant to reimburse providers in *different* ways and on the basis of *individual* contracts that sanction

²⁹ In 2013, the Government has entrusted the Joint Federal Committee with developing concepts regarding cross-sectoral quality regulation. As the existing regulatory system is blamed for facilitating the shift of health care responsibilities from one sector to another (e.g. by early hospital discharge), the idea came up to develop schemes for measuring, for a given patient, the relative shares of the involved providers in the actual quality outcomes.

³⁰ In the U.S., the selective purchase of care services is a long-standing activity of the so-called 'Health Maintenance Organizations'. There are some further areas in which sickness funds operate in this mode. For example, they buy stocks of generic drugs for their enrollees with a pharmaceutical company (after tendering). Selective contracts can also be closed with suppliers of therapeutic aids (at local level).

³¹ Sickness funds are purchasing packages of service provision with a group of suppliers from different sectors (eldercare agencies, drug companies, hospitals etc.). In many of these projects, case managers oversee the process of service provision across sectors.

(alleged) good or poor quality. Thus far, providers and the States (the *Länder*) oppose such models: The former worry about greater economic pressure from the funding bodies whereas the States see themselves bound to a legal remit of ensuring service provision should a local provider fail (and this may easily happen in a pay-for-performance landscape). However, as a regulatory concept, P4P schemes are meanwhile endorsed by major political parties and by health economists including those providing advice to Government (SVR, 2012).

3. Discussion

Looking at our evidence from a comparative perspective, we observe similar tendencies amidst unsurprisingly great institutional variety between the three health care systems. The three countries have seen various policies geared towards more benefit harmonization, albeit with different objectives. In Mexico, reforms aimed at entailing a more universal access to services and less out-of-pocket spending, especially in the case of SP. In Germany and Norway, the focus was primarily put on more comprehensive service quality. The institutions addressed by reforms are dissimilar, too: The reorganization of the German system is targeting providers; in Mexico, it concentrates on health care administration; in Norway, both levels are affected.

However, as the evidence shows, the three countries share a number of communalities. All see institutional change in which the *NPM agenda* makes itself felt – although most management reforms do not follow the orthodox version of this agenda. In Germany, traditional intermediary ‘self-administration’ is operated alongside growing marketization and selective contracting rolled out by the sickness funds. Concerning Norway, pure NPM (featuring marketization and the like) has never been popular here either; what is more, the use of quasi-NPM elements has been confined to internal arrangements in the public sector before being complemented by a ‘post-NPM’-movement centring on formalized interorganizational collaboration. And still, in this country as well, management reforms have brought greater differentiation among the various units of the health care system since providers have become independent (public) enterprises and are subject to top-down performance control through which they become rivals (at least symbolically). Concerning Mexico, the influence of NPM is obvious, too – despite the fact that regulations have not followed the respective orthodoxy in many respects. With recent reforms (and also with new plans for another reshuffle of the health care system), major units of the country’s health care administration are expected to embark on contracting

with providers and on numeric performance evaluation under the auspices of public sector ‘managerialism’.

At the same time, there is a general concern for more comprehensive (universal) service provision across the three countries. In Mexico, benefit harmonization has been an important, if not the most essential, official driver for management reform. While this is an objective gaining dominance throughout Latin America, it also plays a role in more mature health care systems. Thus, regulators in Germany invest in quality regulation meant to entail improved services to all, despite the plural provider landscape. In Norway, the impetus towards integrated and coordinated health care appears very strong within an already relatively uniform administrative set-up.

Interestingly, however, the tools employed for meeting this objective are often prone to create greater disorganization within the overall health care system *whatever* the latter’s institutional set-up and state of development. In Mexico, movements towards benefit harmonization, epitomized by measures to unify plan coverage and to establish single-purpose expert organizations with regulatory functions, go alongside measures introducing volatile arrangements and a complex multi-level administration. The popular insurance scheme, viewed meanwhile as not delivering on promise, was meant to cover greater sections of the populations. Yet this was to be achieved by arrangements in which decentralized agencies were meant to contract services here and there, according to existing opportunities, and depending on an insecure balance of power concerning the respective interorganizational relationships (e.g. with private sector providers), as well as intergovernmental relationships (among the three levels). In that sense, the more or less implicit use of NPM instruments seems to set clear limits to benefit harmonization and increasing the problems of accountability.

In comparative perspective, then, one can discern *stunning parallels*. Regardless of existing differences in the institutional set-up or the respective state of development of the health care systems under study here, major dynamics appear surprisingly alike on the whole. While regulatory change is country-specific regarding its ‘raison d’être’ and its orchestration, the paradoxical character of what can be coined *managerialist modernization* is international in kind. Disparate health care systems are exposed to a similar meta-configuration which is indicative of the public management of health care becoming ever more globalized. Tensions between control and autonomy seem to be similar. There is one regulatory ‘wind of change’ even though it affects specific systems in specific ways.

Under these conditions, the ‘wicked problem’ of fragmented health care system is permanently reproduced in the encounter of (‘post’) NPM and initiatives that aim at greater harmonization. Regarding the wider implications of this, the least one can say is that the movements depicted above put all systems under permanent strain regarding the very activities undertaken to meet public expectations. Given the existence the overall hybrid reform agenda, those instances involved in the day-to-day operation of the health care system (e.g. administrative agencies or hospitals) are facing a contradictory and volatile task environment, and their destiny seems to be the completion of Sisyphean tasks which implies a waste of energy and public resources. And the role of the Ministries of Finance is still poorly studied. The pattern shown by these experiences and the similarities in their development and implementation, may suggest that although there is a tendency for the harmonization some effect lead to potential tensions in terms of accountability relations and weak coordination.

Under these conditions it seems unlikely that there will be a quick progress in the development of health care systems in Mexico and in other parts of Latin America. There are good reasons to assume that the improvement of health conditions and a greater social protection against (the material consequences of) illness is obstructed rather than endorsed by the international mainstream in public management, also in places where NPM comes into play in a more hybrid or disguised way. Our analysis suggests that management reforms in Mexico have thus far been based on inconsistent social policy designs which are a burden to the live of many citizens. Managerialist modernization also produces problems in Europe, yet such difficulties become existential where a growing section of the population is denied access to decent health care. Maybe that learning from Western welfare states is not the best solution in this configuration.

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