Original Articles

The Decentralization of Human Resources and the Health System in Mexico

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Introduction

The Mexican health system has embarked on a reform process where one of the challenges of the health system is to provide care for the 95 million inhabitants of the country. Since 1943, the Mexican health system has developed to its present structure, which is divided in the following ways: a) the social security system covers 47.7% of the national population; b) public assistance covers 43%; and c) the rest is covered by a broad variety of private services (10%). Within the social security system, the most important institution is the Mexican Institute of Social Security (IMSS), and within the public assistance sector we have the Health Secretariat (SSA)(1).

The health system has presented multiple problems, including a marked institutional stratification, an impressive financial differentiation between the social security institutions and other public institutions, the duplication of coverage of the uninsured population and the existence of population groups that have no coverage(2).

At the beginning of 1995, 10 million people were estimated as having no real access to health services. According to official data, by 1998, thanks to the actions of the Coverage Expansion Program, the SSA reported 7 million more Mexicans receiving coverage.

On the other hand, during the past 15 years, Mexico has gone through a series of economic difficulties which have made it impossible to fully carry out its social policy objectives. One of the most critical situations was in 1995, when the Gross National Product (GNP) decreased 6.2%. The social public expenditure, as a percentage of the GNP, has not shown substantial growth in the last few years: it went from 6.6 in 1991 to 8% in 1996. This is also reflected in the total health sector expenditures, where in 1991, the percentage with respect to the GNP was 3.8 and in 1996 was recorded as 3.9(3).

Two Decentralization Processes in the Health Sector

The first attempts towards a reform of the Mexican health system were made in the 80's. During the 1982-88 period, a first effort was undertaken to decentralize the health services and structure of all institutions covering the uninsured population(4).

The decentralization plan set forth an adequate redistribution of responsibilities between the three governmental levels and the organic integration of health care services for the uninsured population, under the management of the state governments. These were the means to achieve the ends of the National Health System, that is, to progress towards universal coverage and improved quality of health services(5). The counties were proposed

to be the trustees of resources and powers, as well as be responsible for health services management.

In order to put the **Health Services Decentralization Model for the Uninsured Population** into operation, joint efforts were required from health sector agencies, state governments, labor unions, etc., carried out through actions which had to reach the municipal level and the state legislatures.

A fundamental aspect of the Model appears in the decree of March 8, 1984, which states that decentralization should be a gradual process in order to avoid deterioration in the operation of services and to make their control and evaluation possible. This gradual approach allowed for decentralization to be carried out in two stages, one for programmatic coordination and another for organic integration(6).

The main problems encountered in the integration of services were the following: 1) the organic-functional structures had varying degrees of disorganization and lacked well defined hierarchical levels; 2) the existence of a marked trend towards centralization at the state level; 3) the lack of adequate health diagnoses and their uses according to real needs; 4) the lack of coordination between the different institutions in the Sector; and 5) the existence of precarious information, supply, conservation, maintenance and human resource management systems(7).

The decentralization process showed no progress between 1988 and 1994. Political, financial and institutional disagreements played a major role in this standstill. As of 1995, with the beginning of the present administration, decentralization was considered one of the fundamental objectives to be achieved in the health system, but this time it would be within the framework of a broader and more ambitious process which is the health sector's reform project.

In March, 1996, the Official Diary of the Federation published the **Health Sector's Reform Program for 1995-2000.** Among the objectives of this program, we find the following: to expand social security coverage, to avoid duplication in the operation of services, to introduce incentives for the quality of care offered to the open population through the decentralization of services offered by institutions, and to provide essential health services to the population that is presently not covered.

Within the **Reform Program**, the decentralization of the SSA service structure is considered a fundamental process that brings together 80 years of experience in order to provide continuity. Actually, the purpose of the new decentralization phase is to go deeper into the process in the states that were first decentralized and, at the same time, to start the process in those states where it hasn't begun(8).

The creation and consolidation of the State Health Systems continues to be the national system's present strategy. With this, the idea is to end the centralist trend in the administration of health resources and to avoid duplication in the production of services for the same populations in different public institutions.

In the medium term, the State Health Systems will have the responsibility to care for the health of rural and marginal urban populations.

Among the decentralization processes promoted in Mexico, there are broad differences, for example, the following two:

1) In the 80's, there was no progress in the transfer of resources to the state governments (even personnel pay checks were written in Mexico City).

In the second process, the SSA reported that towards the end of 1997, 6,132 million pesos (at a 7 pesos per dollar exchange rate in those years) were transferred to the states, comprising 7,400 units and 103 thousand workers.

2) An important action of the Mexican government was to cover the most marginal and isolated rural populations through the IMSS-Solidarity Program.[a] This program has peculiarities that make it different from the other services: it has technical, economic and infrastructure support from IMSS; most of the personnel belong to IMSS and receive significant labor and economic bonuses; the service is provided in rural clinics located in the poorest areas of Mexico; a community participation system has been developed where the population participates in the clinic's management.

In the first process, all resources belonging to this program went to state services, while in the second process, there was great resistance to any kind of change in the IMSS-Solidarity structure.

Decentralization and Human Resources in the Health Sector

The decentralization processes have not been accompanied by a substantial increase in the public expenditure allocated to the health sector. It is difficult to state the contrary, although this is explicitly one of its objectives.

The behavior of health expenditures responds to governmental policies and to the recurrent economic crises. In 1990, the budget of the institutions that provide care to the uninsured population was 1,122.6 million dollars (md); in 1995 it reached 1,244.9 md. and in 1996 it was 1,949 md. In the meantime, the population went from 83,488,000 inhabitants in 1990, to 93,181,000 in 1996[(9)].

With respect to human resources, it is clear that the increase in these resources is in no way related to the decentralization processes. In 1983, at the beginning of the first decentralization process. the SSA had 17,122 doctors and 20,770 nurses; in 1989, once the process had been stopped, there were 24,958 physicians and 37,121 nurses; by 1996, once the second decentralization process had begun, SSA had 37,620 doctors and 51,056 nurses (SSA, 84,90,98).

Although an increase in the numbers of health personnel is obvious, if we relate it to population growth, the results will allow us to see the progress. In 1990, there were 10.7 physicians and 15.6 nurses per 10,000 inhabitants, and by 1997 the relationship was 12.8 and 17.3, respectively.

The aforementioned data have as their end to put the following analysis into context. Decentralization and its effects on human resources may be identified from three specific aspects: distribution, regulation and management.

Before going on to the analysis of these three components, it is worth mentioning some elements of the political-institutional ambit which we believe to be fundamental to an understanding of the phenomena which are the objectives of this document.

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[a] The first coverage extension progam was created in the mid 70's. The program's service structure has always been associated with IMSS. Since those years, the administration changed the name of the program to adapt it to the specific objectives of its social policy.

One of the actors having significant weight in the definition of the three aspects mentioned above, has been the Health Secretariat's National Workers' Union[b] (SNTSSA). The presence and negotiation practices of this union have greatly limited the powers of the Decentralized Public Agencies,[b] in each state in 1977, with respect to the management of human resources for health.

Another fundamental actor is the federal government, where a great bureaucratic apparatus sees in decentralization, a potential threat to its control. This is not a matter where state workers with a lower income and limited authority are opposed to decentralization. It's about workers at mid-level and high level positions within the SSA, who over the years have been rotating positions and have created cliques with privileges and power that they want to protect(10). Thus, they prefer to maintain centralized decisions unchanged and to have absolute management of resources.

The SNTSSA has a history which is closely linked to that of the official and corporative syndicalism in Mexico(11). In a succinct manner, it is convenient to specify some points in this respect, in order to facilitate the analysis expounded further on.

The traditional relationship between the state and the official unions has been one of patronage. In exchange for worker control, union leaders (who usually remain in their positions several decades, blocking the democratic participation of workers by all means at their disposal), receive political and economic power from the government(12).

This situation, of mutual benefit to both agencies, has generated dependency, blackmail, corruption, corporativism, untouchable power groups and political concessions, among other phenomena. An example of this is that in the present directorship of the SNTSSA, the general secretary has been in this position for more than 10 years while not also holding the position of federal congressman of the official party.

Since its establishment, the SNTSSA has been in charge of labor relations before the federation and the Health Secretariat. Every two or three years, there is a revision of the General Labor Conditions (which are similar to the Collective Labor Contracts and, by law, cannot exist for government employees since they have constitutional restrictions; for example, they have no right to strike), where everything related to the 140,000 workers of the Secretariat (mostly physicians and nurses) is written down.

Considering the above, it is obvious that in the health sector's decentralization process, the national union becomes a central actor and, in some cases as we shall see further on, will play a decisive role in matters pertaining to human resource policy.

The SNTSSA was one of the main obstacles to the decentralization process in the 80's. One of the main arguments against it was the union's integrity; they were afraid of it disappearing the moment human resources were decentralized to each of the states of the federation(13).

That is, they were afraid that when employees became directly dependent on the state executive power, the national union would lose its affiliates. In its place, 32 unions could arise (one for each state, plus the Federal District).

In 1985, the new general labor conditions of the Health Secretariat were approved, which included a chapter that regulated the decentralization of services.

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[b] State-level entities created by the federal level to handle the transfer of federal funds to executing agencies.

Workers of the decentralized services continued to be federal employees and kept their affiliation to the Secretariat's national union. The heads of the State Services, had powers that involved labor relations in order to solve individual conflicts.

In the second process (during the 90's), the SNTSSA played an important role in defining and reaching the objectives of decentralization. During this second stage, labor relations between the SSA and its personnel have been clearly established. In relation to this, it is worthwhile to examine the general agreements, since these are the ones that determine the narrow margin that the states have with respect to distribution, regulation and management of human resources.

In a reiterative manner, the **Agreement for the Decentralization of Health Services** mentions labor relations which, among other aspects, have to do with conditions set by the union in order to accept the decentralization program.

It states that: **"In the health services decentralization process,** ***rights acquired by workers should be guaranteed--rights such as unremovability,*** **the job catalogue, roster, permutation and other diverse rights,** *codified in section B of Article 123*[c] *and is Regulation Law and in the General Labor Conditions of the SSA and in its* future reforms, including the generic and specific bonuses, ***as well as the updated payment mechanisms*** **and the agreements made with the SNTSSA with respect to this matter, according to the federal law"** (italics added by the authors).

Distribution of Human Resources

In the 80's, the policy followed with respect to human resources was to keep all matters pertaining the location of job openings under the control of the federal government, through the Health Secretariat.

This was the case as well with respect to personnel distribution.

All decisions with respect to levels, occupational categories, locations where services would be rendered, were made in the capital of the Republic (Mexico City), between Health Secretariat authorities and the SNTSSA leaders. The decentralization process had no impact on this area.

In the 90's, we could say that personnel distribution will remain unchanged, at least in the medium term, due to agreements signed between the federal and state authorities and the SNTSSA. This has been perfectly regulated in the first document mentioned when we spoke of **unremovability** as one of the acquired rights which cannot be waived.

Thus, in the states, it will not be possible to progress towards personnel changes from one medical unit to another.

This stems from the fact that those conditions under which decentralization arose are still being regulated by the federation.

The decentralized public agency (at the state level) is regulated by the General Labor Conditions signed by the Health Secretariat, and this was not modified. This was one of the most important agreements leading to the decentralization process. This situation does not seem to be headed for change in the next few years.

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[c] Section A of article 123 of the Constituion, establishes the existence of workers' rights such as the collective labor contract and the right to strike (e.g. the case of IMSS employees). Section B does not consider these prerogatives (e.g. SSA employees).

Employees stay within the present law and seek union support. Any plan seeking to balance the personnel at a geographical level will have little chance of success. Actually, work assignments at a different location are generally not convenient for workers. This situation is permanent; changing the laws is a long and complicated process and their effect is not retroactive.

One of the results of the above-mentioned situation is the lack of personnel in marginal rural areas where there is also a scarcity of infrastructure and material resources. The possibility of offering financial incentives to employees who are willing to move to rural areas is still remote. There is no previous experience within the SSA. Doctors usually stay in these zones on a temporary basis and these are generally physicians who have graduated recently and are sent to carry out their social service obligations.[d]

Thus, part of the health services that exist in the most isolated and marginal communities are rendered through the rural clinics of the IMSS-Solidarity program, which is financed by the federal government to serve the population that lives in extreme poverty. Medical personnel working at these clinics have a different status since they are employed by IMSS and have more favorable working conditions, compared with physicians at SSA.

Regulation of Human Resources

In the 80's, the regulation situation was not much different from that of distribution. The Health Secretariat kept the power to provide physicians with their registration numbers. The same thing happened with norms regulating professional practice. On the other hand, the Board of Education (SEP) continued to be the only agency capable of granting the professional certificate, without which a doctor may not be hired by public institutions. In practice there were two obligatory registrations[e], but only one of them was legal.

On the other hand, health personnel training policies continued with their own dynamics and showed no close or determining links to the decentralization process. Higher education institutions, as well as hospital centers with residencies, continued defining their actions in a relatively autonomous way.

Labor relations continued to be collective, however, aspects such as the regulation of professional training, or the definition of technical capabilities, or certification were practically absent from the General Labor Conditions.

With respect to the administration of human resources, some modifications were done. When medical services from different institutions were integrated into one agency at the coordinated health services, different personnel with different working conditions and different positions[f] , had a chance to meet (the main difference being between state and federal positions).

During the decentralization process that started in the 90's, the regulation of human resources training was not included in the official project and no proposals have been

[d] Last year of the medical course, when students must practice in rural areas in order to receive their degrees.

[e] Legally, only the General Directorship of Professions (DGP), belonging to SEP, may enable professionals to start their practice. The SSA registration only applied to physicians who preferred to carry out the procedure rather than be liable to a sanction (or sometimes they just do it out of habit). The registration disappeared recently and the only one that remains in force and is still legal is the DGP's.

[f] Permanent job positions.

developed on the changes in relationships, coordination and cooperation with higher education institutions. With respect to professional practice, a determining participation of the states is not foreseen either.

According to the agreement between federal authorities and the SNTSSA, some aspects where the states will have no involvement include job catalogue, roster and permutations.

Human Resources Management

During the first decentralization process, one of the main actions was the salary homologation (upwards) between workers who had federal posts and those who had state positions. This event meant that state employees increased their earnings to be equal to federal personnel. This happened at the federal level, in all 14 decentralized states.

Homologation was part of a national negotiation between the SSA and the SNTSSA. The union continued to be the main representitive of the workers and, as such, negotiated all kinds of wage increases and bonuses; the results of these negotiations were extended to all unionized workers of medical services in the decentralized states.

Also at the national level, both agencies continued defining everything related to roster regulations, training, incentives for attendance, punctuality and job permanence, as well as regulations on safety and hygiene.

In the process during the 90's, the states are greatly limited to take control over personnel income. Everything related to economic incentives for productivity, for attendance, punctuality and permanence, generic and specific bonuses, **as well as the present wage updating mechanisms**, are determined at the central level. Through the negotiations, the SNTSSA managed to keep conventional practices for an indefinite time. With decentralization, personnel job descriptions were not modified, nor were schedules and work loads.

Future Trends

The health sector's reform, with respect to decentralization and to distribution, regulation and management of human resources, has several medium term problems, taking into account that the most ambitious goals are set for the year 2000.

- In 1999, the General Labor Conditions (CGT) may be revised by the SSA and the SNTSSA. The dominant trend is that authorities will not choose to accept that which refers to the union's national representation or its leadership. There is no project to this effect. On the contrary, a new series of demands for benefits and salaries is expected, which will be to the advantage of more than 100,000 unionized workers.

The central bureaucracy has maintained control over the states for many years and continues to have an influence on the decision-making process. Thus, its position will be to not favor the distribution of human resources according to what has been established and signed in the decentralization agreements with each state and in the CGT. The unremovability will remain the same, at least in the medium term.

Regulation and management of human resources will not go through noticeable changes before the year 2000.

-By the end of the first trimester of 1998, decentralization and the disappearance of the IMSS Solidarity Program had not begun. The main and most powerful actors opposed to these changes have blocked the process. Most noticeable is the role of the IMSS union, with more than 300,000 workers, which is leading a new non-official workers union.

Conclusions

As we have observed throughout the text, health services decentralization is a strategy designed to strengthen the production of services for the population that is not covered by social security institutions. One of the main problems faced by decentralization in the 80's was the lack of interest that the social security institutions showed with respect to participating in the process.

Actually, among the most conflicting points was the disincorporation of the service structure for the open population, supported by federal funds (IMSS Solidarity Program), which was IMSS's responsibility.

In the human resources area, historic differences between the social security institutions and the social assistance institutions, with respect to the supply of health personnel, were kept as a function of the greater capability of the first ones to hire personnel at different levels[14].

Presently, the health sector's reform seems to express itself through two parallel and disconnected processes. One version of the reform affects the uninsured populations. In this version, decentralization plays a fundamental role, since it is conceived as a strategy to erradicate the duplication of services, broaden coverage and thus, increase efficiency in the use of available resources.

The creation of State Health Systems, based on the conjunction of the coordinated health services belonging to the SSA and the IMSS Solidarity units, with federal-state financing is considered to be an appropiate tool to provide coverage to this population.

The viewpoint presented throughout this document tries to analyze political aspects which are normally not considered in order to understand the execution and results of health policies. In this case, we are interested in understanding the link between the decentralization process and three aspects of the human resource policy: distribution, regulation and management. Our focus, however, attempts to document the processes, more than the results, since these will have to manifest themselves during the coming years. The scientific value of documenting the process allows us to identify explicit and hidden links between the actors in this process, which are strong determinants of the final results.

This analysis does not show an optimistic view of the facts. It is interesting to point out the unremovability of the aspects surrounding the human resource policy within a general process, that of decentralization, which in theory is extremely dynamic.

The distribution of personnel at the state level is conditioned by the negotiating capability of the national federal union, and management is subordinated to the sum of financial transfers from the federation to the states and to the inability of the latter to define their management objectives according to local capabilities.

However, as mentioned by Hall[15], the role of planning cannot be dismissed since it is the only way to guide the future development of human resources. Today, more than ever, the state has the responsibility to make sure that in defining this process, all actors

who have an interest in the field should participate and that quality health services should be efficiently provided; this is the goal to be reached.

We should also not dismiss the fact that the personnel payroll represents 65% of the SSA budget. Although the panorama presented here is not characteristic of the whole country, it does represent the states with the most recent decentralization experience and with the greatest volume of population in conditions of poverty. Decentralization in Mexico still has a long way to go in order to achieve its objectives in the field of human resources.

Table 1 Obstacles and Solutions in the Administration of Human Resources in Mexico's Health Sector Decentralization

	Obstacles	**Solutions**
Distribution	The unremovability of personnel (in the CGT) at the federal level between the SSA and the SNTSSA.	Sensitization at the state level, so that workers will accept assignment changes, responding to needs in services and without violating the CGT's.
Regulation	Normativity is maintained in the SSA and, based on manuals and protocols, regulations are carried out at a national level, with respect to medical practices and personnel admissions, among other aspects.	No formula is foreseen for the states to regulate; besides, this is considered to be a responsibility of the federal level.
Management	Agreements on everything related to salaries, benefits, roster movements, are made at a central level, between the SSA and the SNTSS.	Obtaining financial resources at the state level. Innovative forms of personnel contracting.

Table 2 Main events in the decentralization of health services for the open population in Mexico, 1983-1997.

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February 3, 1983	Article 4 of the Political Constitution is modified to include the right to health.
March 8,1983	The Decentralization Model of Health Services for the Open Population is made public.
August 30,1983	The Health Services Decentralization Program is published in the Official Diary of the Federation.
August 31,1984	The powers of 8 states are deconcentrated.
1985	Coordination Agreements for the organic integration and operative decentralization of health services for the open population are signed.
1986	Coordination Agreements for the decentralization of health services are made.
March 11, 1996	The **Health Sector's Reform Program, 1995-2000**, is published.
September 25,1996	The **National Agreement for the Decentralization of Health Services** is published.
1997	Decentralization Agreements are signed with all states; 6,132 million pesos, 7,400 units and 103,000 workers are transferred to the states.

Sources: *Diario Oficial de la Federación (The Official Diary of the Federation), La Jornada, El Financiero* (newspapers), 1983-1997.

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