From Analysis to Impact
Partnership Initiative Case Study Series

Study No. 15, July 2013

Health, Citizenship, and Human Rights Advocacy Initiative: Improving Access to Health Services in Mexico

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Introduction

In early 2009 *Fundar, Centro de Análisis e Investigación* initiated an advocacy project called Health, Citizenship, and Human Rights *(Salud, Ciudadanía y Derechos Humanos,* SCyDH*),* which aimed to improve access to and availability of health services for socially excluded groups in Mexico.[2, 3]

Three years into this initiative, Fundar's approach has evolved considerably. Though the organization began with a rather general interest in health services for the poor, it has since focused its campaign strategy on addressing a series of specific budgetary issues affecting the *Seguro Popular* (SP), the agency tasked with providing healthcare to the country's 52 million uninsured. For Fundar, the focus on the SP is merited because of the enormous financial scale of the program.[4] How well the SP is managed has important implications for approximately half the country's population — the half that consists mainly of impoverished or socially excluded groups without proper access to health services.

In three years, by reaching out to grassroots organizations as well as to policy makers, Fundar has had a real impact on public policy — but the work has also had a surprising impact on the organization itself. Fundar has evolved from an organization known primarily for its technical research and analysis on federal budgets into a policy advocacy network. Indeed, the way this project developed in its first three years (2009-2012) illustrates important organizational lessons. This case study tells the story of how the organization managed to acquire the skills and tools necessary to move toward health policy advocacy in the interest of vulnerable people.

This case study is part of an effort of the International Budget Partnership (IBP) to document how the work of civil society organizations in analyzing and monitoring public expenditure can help influence public decision making and bring about changes in government action. The central questions this case study seeks to answer include: How does an organization with a history of work centered mainly on research and analysis on federal budget policy, adapt to conduct sustained advocacy work on a large-scale policy involving different branches and levels of government? What

[1] Special thanks to Jonathan Fox for his valuable inputs and feedback on this case study.
[2] Fundar is a civil society organization established in 1999 in Mexico for the purpose of developing mechanisms to strengthen citizen participation in solving social problems. Its work emphasizes the importance of analyzing government budgets as a tool to protect and promote respect for human rights.
[3] The direct responsibility for implementing this initiative lies with three researchers from Fundar's Budget and Public Policy Area.
[4] According to the administrative classification of the budget, *Ramo* 12 corresponds to health and it includes the resources for the operation of the Social Protection System for Health (*Sistema de Protección Social en Salud,* SPSS). By 2011 the SP budget represented 38.7 percent of the Ministry of Health's total health budget (*Ramo* 12 and *Ramo* 33-FASSA) (Budget Integration Process 2012, Department of Planning, Organization and Budget, SS).

are the main contextual factors that enable or impede federal budget advocacy work by civil society organizations in Mexico?

The Issue: What Was the Initiative Responding To?

The provision of public health services in Mexico has been traditionally structured according to a fragmented and biased service provision model. Under the National Health System, several public institutions operate as health insurers/service providers under a scheme that privileges individuals working in the formal economy (located mostly in urban areas) and tends to exclude urban and rural poor people without employment, self-employed people, or workers in the informal economy — almost one-third of the economically active population (see Figure 1).[5,6] Since the 1960s the Ministry of Health (*Secretaría de Salud,* SS) has provided healthcare services to the uninsured population (*población abierta*) through public hospitals and clinics run by the State Health Ministries, while the Mexican Institute for Social Security (*Instituto Mexicano del Seguro Social,* IMSS*)* and the Institute for Health and Social Security for Government Workers (*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado,* ISSSTE) provide social security for workers in the formal economy and their dependants (almost 50 percent of the population).[7,8] Each of these institutions controls their own financing systems, has their own unions, builds health infrastructure, and provides services to their target population. However, IMSS and ISSSTE have significantly more resources, even though the SS must serve 50 percent of the population.[9]

The modifications introduced to the General Health Care Act in 2003 included the creation of a Social Protection System for Health (*Sistema de Protección Social en Salud,* SPSS) and entailed one of the most significant reforms to the Mexican Health System.[10] With those reforms, Mexico was expected to move toward a more equitable and efficient health system that might guarantee access to health for its entire population.

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[5] National Occupation and Employment Survey, INEGI, 4th trimester (2009), www.inegi.org.mx/inegi/contenidos/espanol/prensa/comunicados/estrucbol.asp; and Organization for Economic Cooperation and Development "Reviews of Health Systems: Mexico 2005" OECD Publishing, 2005.

[6] The Health and Assistance Ministry, established in 1943, was initially in charge of providing public health services to the entire Mexican population. However, by the end of that decade, the IMSS was created with the mandate to manage the health and social security schemes for workers in the formal economy. The ISSSTE was established in 1960, following the same logic as the IMSS, but in this case with a mandate to provide social security to state employees. The Ministry of National Defense and PEMEX (Petroleos Mexicanos — Mexico's state-owned oil company) later followed the same pattern and established their own healthcare and social security systems for their employees. Thus SSA and its counterparts at the state level remained the healthcare provider for the "uninsured" population. By the end of the 1970s, considering the funding and infrastructure limitations of the SSA, the government established the IMSS-COPLAMAR Program (financed by the government but operated by the IMSS) with the objective of providing health services to the rural and indigenous population, while the SSA would still be responsible for serving the poor and marginalized urban uninsured population. This program later became *IMSS Solidaridad* and today is known as *IMSS Oportunidades*.

[7] During the 1980s, the government decided to gradually decentralize health services to correct some of the imbalances in resources, infrastructure, and quality of healthcare between the different providers, as well as their lack of coordination, leaving the responsibility for healthcare provision to the states. Today, this system includes 32 different state health services, with the federal health ministry limited to a regulatory role. It was also in this period that the Mexican Constitution finally incorporated the right to health protection (Article 4). However, decentralizing health services to the states created additional problems that persist today and negatively impact the provision of health services, namely lack of technical capacity and a highly discretionary use of public health resources, among others.

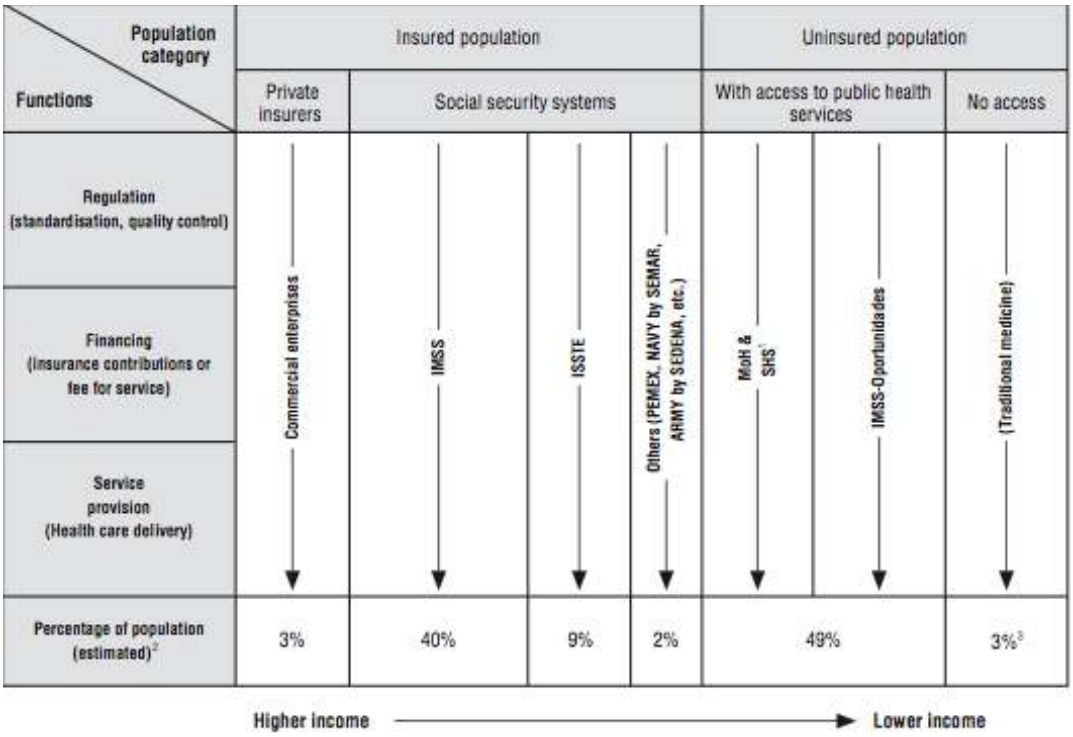
[8] A more detailed description of the historical development of the Mexican health system can be found in the document prepared by the OECD in 1995 as part of an institutional evaluation of health systems.

[9] In 2000 average per capita fiscal spending was approximately $78.63 in IMSS, $143 in ISSSTE, and $54.50 in services for the uninsured population. See, Jacqueline Arzoz and Felicia Marie Knaul, *Inequidad en el Gasto del Gobierno en Salud* (Mexico DF: Fundación Mexicana para la Salud, Caleidoscopio de la salud, 2003).

[10] The SP was established in 2001 as a pilot project, which was fully implemented from 2004.

The main objective of the SPSS was to provide universal health insurance to approximately 50 million uninsured people, with the goals of: 1) extending health coverage to the uninsured population or *población abierta*; 2) reducing out-of-pocket medical expenses; 3) reallocating federal resources to the states according to their affiliation rates; and 4) injecting new resources into the health system in a more integrated manner. The SPSS was also meant to introduce a first step toward coordinated financing and service provision functions in the health system, since those affiliated are supposed to be able to request services from any of the public healthcare providers.

Figure 1. Mexican National Health System Model



Source: OECD Reviews of Health Systems – Mexico (2005)

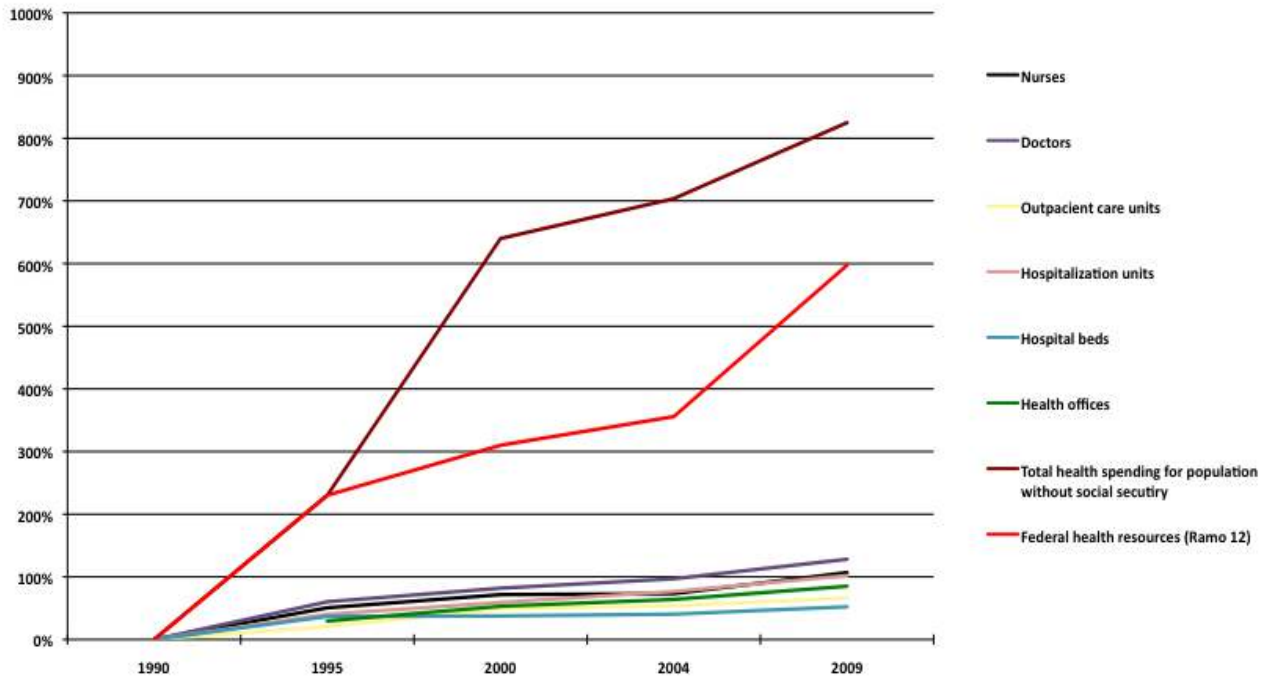
However, the expectations created by the introduction of the SPSS are far from being fulfilled. For the past seven years, the SP worked intensively toward reaching the goal of affiliating the uninsured (51.8 million people), reaching it in 2011.[11] Although significant improvements have been made, there are still several problems associated with access to healthcare among poor and marginalized populations, even if they are affiliated. The Mexican public health system is still characterized by a substantial fragmentation and lack of integration between insurers/providers, duplication of efforts and populations served, spending inefficiencies, service provision inefficacy, and inequality of access.[12]

In principle, a greater infusion of resources into institutions that provide services to the uninsured population should gradually reduce shortages in health-related infrastructure and human resources,

[11] Comisión Nacional de Protección Social en Salud (CNPSS) "Informe de Resultados del Sistema de Protección Social en Salud," Mexico, 2011.
[12] FUNSALUD, "La Salud en México 2006/2012. La Visión de FUNSALUD, 2007," Fundación Mexicana para la Salud, 2007.

thus better serving that population. However, while there has been a significant increase in financial resources for health services for the uninsured in Mexico over the last 20 years, this has not led to greater investment in health personnel and infrastructure (see Figure 2).

Figure 2. Total healthcare spending vs. material and human resources for the uninsured population, 1990–2009 (percentage increase)



Source: Calculations based on information from the *Sistema de Cuentas en Salud a Nivel Federal y Estatal* (Federal and State Level Health Accounting System, or SICUENTAS), Ministry of Health, Directorate General of Health Information, Mexico 2011.

That is, although affiliation to the SP "guarantees" people the healthcare they need and are entitled to, in practice this has not translated into greater access to public health services, or quality care. In principle, the population covered by the SP could receive services from any of the health facilities within the National Health System. In practice, attention to this population is mostly concentrated in the clinics and hospitals operated by the State Health Services — which have a marked deficit in investment in material and human resources — and only marginally in those facilities operated by IMSS Oportunidades. Therefore, even though the Ministry of Health's media strategy promotes SP as a program that provides access to health and, through universal membership, guarantees the realization of the right to health to all Mexicans, in practice SP affiliation does not guarantee either.

By promoting the SP as a "passport" to quality healthcare, this administration has placed itself in a delicate position, as public health providers are still unable to properly care for the uninsured. At 10 years since its implementation, the SP is a healthcare insurance *possibility*, but it is an unequal "passport" to quality services. In other words, SP could guarantee healthcare as long as the human and material resources are there to provide it; however, inequitable distribution of resources, health infrastructure, personnel, and medical supplies to care for the uninsured currently prevail.

Since the SP is the most important health policy program for those without social security in Mexico today, Fundar decided to target it, identifying certain areas where the program fails to ensure the right to health, and the consequences of this on people's quality of life.[13] In 2001 Fundar began to establish a line of research and analysis on health budget policy, emphasizing the close connection between health financing, health infrastructure, and the provision of health services. This work has been developed over the years and takes a rights-based approach, i.e., trying to link deficiencies and irregularities in health service provision with the duty to guarantee the right to health for all.

In 2004, following the creation of the SPSS, Fundar resumed its research and analysis that sought to identify specifically how the inequitable distribution of health resources and the lack of investment in infrastructure and health facilities was leading to disparities in access to quality care. In 2007 Fundar created a regional initiative in Mexico and Central America to monitor legislative, judicial, and government action to advance the implementation of the right to health, resulting in a publication titled "*Cinco Miradas Sobre el Derecho a la Salud. Estudios de Caso en México, El Salvador y Nicaragua*" ("Five views on the right to health. Case studies in Mexico, El Salvador and Nicaragua").[14]

Subsequently, in response to the announced reform of the *Ley General de Salud* (General Health Law) for 2010, in which important health policy changes were expected, Fundar prepared for health advocacy work, in part, by creating the *SCyDH* initiative specifically to monitor SP spending and propose changes to the program's budget. The strategy was to introduce transparency and accountability reforms to the federal budget, which at some point would be used to promote the provision of better healthcare services for marginalized populations in Mexico.

Fundar sought to achieve change on two levels:

1. *Greater transparency and accountability in how funds for the SP are spent.* Given that health policy in Mexico is decentralized, the federal government transfers 80 to 85 percent of allocated resources to the state authorities to meet the health needs of those without social security (see Table 1). The spending of those resources is the responsibility of state governments. However, in many cases state-level budget information is unavailable, and there is a lack of coordination among various agencies and entities involved in executing and monitoring SP resources. This makes it difficult to know how the budget is actually spent and what the main shortcomings and results are in providing SP-related health services.[15]

Table 1. Public expenditure in health for the uninsured population (federal and state)

[13] Fundar considers that in Mexico "in the government sector the debate remains focused around whether social rights are merely policy recommendations on which the State must refrain from acting, as opposed to concrete action in defense of civil and political rights that does occur. Human rights organizations have focused more on complaints and human rights defense (individual and collective), but FUNDAR analyzes the issue from a policy and government budget perspective" (Mariana Pérez, interview, December 2011).

[14] Mariana Pérez (ed.) "Cinco Miradas al Derecho a la salud. Estudios de Caso en México, El Salvador y Nicaragua," Fundar Centro de Análisis e Investigación A.C., 2010. One of the three Mexican cases in this publication focused on SPSS operation. Monitoring was conducted at the federal level (2004-07) to assess Mexico's compliance with its obligations to realize the right to health, considering international guidelines, standards, and law on human rights as its starting point.

[15] *SCyDH* project theory of change, Fundar, November 2010.

Year	Federal spending **BY SOURCE OF FINANCING**			Federal spending **TOTAL** (%)	**Government** spending (%)
	Ramo 12[1] (%)	IMSS-O[2] (%)	FASSA (*Ramo* 33)[3] (%)		
1999	43.9	0.0	56.1	85.4	14.6
2000	41.6	0.0	58.4	84.8	15.2
2001	41.3	0.0	58.7	85.4	14.6
2002	42.4	0.0	57.6	82.8	17.2
2003	40.9	0.0	59.1	84.0	16.0
2004	37.5	7.8	54.7	83.6	16.4
2005	43.5	6.6	49.9	83.7	16.3
2006	46.7	6.4	46.9	84.1	15.9
2007	51.9	5.7	42.5	84.1	15.9
2008	56.0	5.1	38.9	83.4	16.6
2009	58.2	5.5	36.3	83.2	16.8
2010	59.2	5.4	35.4	81.3	18.7

[1] Administrative fund for the health sector.

[2] IMSS Oportunidades operates with federal government funding and is supported by the administrative structure of the IMSS.

[3] *Fondo de Aportaciones para los Servicios de Salud* (Health Services Contributions Fund—FASSA), included in *Ramo* 33.

Source: Calculations based on information from the *Sistema de Cuentas en Salud a Nivel Federal y Estatal* (Federal and State Level Health Accounting System, or SICUENTAS), Ministry of Health, Directorate General of Health Information, Mexico 2011.

2. *Legislative reforms for more efficient expenditure control of SP resources.* Control and accountability mechanisms for the SP budget execution are currently insufficient, which allows states to allocate resources in opaque and discretionary ways. The consequences are reflected in at least three deficiencies that negatively impact access to health services: 1) shortage of medicines, (2) high out-of-pocket spending, and 3) lack of investment in infrastructure and medical equipment.[16]

In connection with the supply and availability of medicines that the government is mandated to provide, Fundar has documented that, although there is a standard for the procurement of drugs associated with the *Catálogo Universal de Servicios de Salud* (Universal List of Health Services, or CAUSES), the states do not comply with it.[17] In some cases state governments pay premiums to benefit private interests — such as pharmaceutical companies — and in others consolidated purchases are not made, missing the opportunity to negotiate discounted prices. This means that the state governments are making poor use of SP resources, disregarding the existing corrective mechanisms to prevent this.

[16] Ibid.

[17] There is an agreement that set out guidelines on the procurement of drugs associated with the Universal List of Health Services for state governments (*Mexican Official Journal,* 26 January 2009), which established specific conditions to be met to prevent the purchase of drugs over a limit specified by the Ministry of Health. CAUSES includes 275 interventions or services for the affiliated population, including drugs and medical procedures.

Another problem is that there is a lack of public information about how much insured families spend out of pocket on healthcare, which makes it difficult to establish concrete measures to mitigate this expense. Finally, according to Fundar's research work on health infrastructure and equipment spending, it appears that there is a recurrent underspending of the SPSS Trust Fund.[18] Meanwhile, there remains an uneven availability of clinics and hospitals in the country.

Because of the scale and the profile of the population served by the SP, the quantity of resources managed, and the different levels of government involved in its execution, its implementation has been the target of much criticism by opposition political forces. While the federal executive insists on the program's success and on its many benefits for people with limited resources, opposition parties consider it a failed policy that has not achieved its stated objectives and as an instrument of electoral mobilization in the face of the 2012 federal elections. Ironically, increased funding to provide health services to the uninsured also means an important inflow of resources to the state authorities themselves. Many of them, regardless of the party in power, have varying degrees of underspending of SP health resources and are not interested in tighter regulations on how those resources are handled.[19] State authorities prefer the status quo, with few restrictions. According to one official, "for the states, the SP is the goose that lays the golden egg. Who is going put limits on that?"[20]

As shown, Fundar's initiative addresses a complex debate on how to operate a health system characterized by a high degree of fragmentation and inequity. This represents a major challenge, both in terms of the program that the intervention targets and the emerging participation of social actors in budget policy analysis and advocacy in Mexico; a practice that has yet to be accepted or considered as an input in government decision-making processes. Therefore, advocacy efforts in this area still have little resonance among policymakers.

Mexico has progressed in the last 12 years toward a legal and institutional framework that is more conducive to citizen participation in public decision making.[21] However, the legal framework has proved insufficient. Official channels for participation have been established to meet the obligation imposed by the legal framework, rather than to substantively involve the citizenry.[22] Thus policy

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[18] The SPSS Trust Fund manages the resources for: 1) covering services related to high-cost diseases or health conditions that are considered catastrophic, 2) strengthening infrastructure, 3) compensating for unforeseen health service demand, and 4) guaranteeing the provision of interstate services. Fundar's main findings show that since 2000, only 25 percent of public works registered on the *Plan Maestro de Infraestructura* (Infrastructure Master Plan, or PMI) have been completed.

[19] Auditoría Superior de la Federación (ASF), "Informe del Resultado de la Fiscalización Superior de la Cuenta Pública, 2008-2010," 2010. The 2009 Public Accounts Audit Report registers underspending of SP resources by the states up to 34.5 percent.

[20] Interview, April 2012.

[21] In June 2002 Mexico approved the *Ley Federal de Transparencia y Acceso a la Información Pública Gubernamental* (Federal Law of Transparency and Access to Public Government Information). In June 2007 Article 6 of the Mexican Constitution, which concerns access to information, was amended to standardize compliance with this constitutional right across the country. Moreover, the introduction of the *Ley de Fomento a las Actividades Realizadas por las Organizaciones de la Sociedad Civil* (Law to Promote Activities by Civil Society Organizations, 2004) has been a positive step in terms of recognizing these organizations as public interest stakeholders. Additionally, in Article 6, Section IV, this law establishes the right of organizations to participate in "social auditing" mechanisms. Finally, the *Ley General de Desarrollo Social* (General Social Development Law, 2004) devotes the whole of Chapter VIII to social auditing, "guaranteeing" citizen participation in auditing and monitoring the government.

[22] Most institutional participatory mechanisms favor consultation processes (voice) without incorporating procedures to allow effective participation in public decision making that can modify courses of action (vote). To mention only one example, the study "The inclusion of civil society organizations in deliberative public bodies in the APF in 2008" shows that in Mexico there are 164 formal mechanisms for state-society interaction documented in different norms and lawss, generally known as citizen councils or committees. Most of their functions emphasize consultation (58 percent), a small percentage considers participation in monitoring and assessment (10.5 percent), and only 5.5 percent of the cases include co-management functions. However, there is no information about how they operate in practice and if they actually perform those functions. (Felipe Hevia, Samana Vergara, and Homero Ávila, "Construcción de

advocacy by civil society organizations continues to be a difficult process in the country. The few studies devoted to examining this issue in Mexico agree that advocacy participation is still very limited, and cases in which organizations have had significant involvement in public policy remain very few.[23] On the one hand, the interaction between social actors and the state has been characterized by paternalistic practices, as well as by a political patronage system, hindering the development of a critical mass of independent organizations active in the public sphere. On the other hand, despite pro-transparency and accountability legal and institutional developments, in practice government machinery remains impermeable to the idea of citizen involvement in public decision making. Consequently, there is no sustained tradition of policy dialogue between civil society organizations and the government, nor are there rules or procedures for enabling effective interaction between citizens and public servants, nor are politicians and decision makers open to incorporating other players in the process of improving government performance. The possibility of successful advocacy is currently associated with the capacity of organizations to "endure" and achieve occasional influence over public officials through informal networks, but not as a consequence of a common basic agreement about the benefit of citizen participation in public affairs.[24]

If one adds to that the technical and analytical capacity required for budget analysis, then Mexico still has very few organizations in this line of work that could exercise a sustained pressure on authorities.[25] In the health field, most organizations focus on service provision rather than budget analysis and public policy. In this context, it is of particular relevance to analyze how Fundar worked to build spaces for advocacy in the health policy budget in order to overcome barriers and move forward with their proposals for change.

What Impact Was Achieved by the Initiative?

According to what various authors propose in terms of analyzing the outcomes of advocacy work by civil society organizations, though concrete policy changes may be the ultimate goal, it is pertinent to consider other achievements, as well.[26] There are different stages and outcomes from a campaign that

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Línea Base para Posteriores Evaluaciones de Impacto Sobre la Inclusión de las Organizaciones de la Sociedad Civil (OSC) en Instancias Públicas de Deliberación. Informe Final de Investigación," INDESOL/CCS-CIESAS, 2009.)

[23] Luis F. Aguilar, "Las Organizaciones Civiles y el Gobierno Mexicano,"*Sociedad Civil: Análisis y Debates* (vol. II, no. 1, 1997), Mexico: Foro de Apoyo Mutuo (FAM) Fundación DEMOS I.A.P. e Instituto de Análisis y Propuestas Sociales I.A.P.; Enrique Cabrero Mendoza, (2000) "Usos y Costumbres en la Hechura de las Políticas Públicas en México: Límites de las *Policy Sciences* en Contextos Cultural y Políticamente Diferentes,"*Gestión y Política Pública* (vol. IX, no. 2, 2000); Manuel Canto (ed.), (1998). "La Participación de las Organizaciones Civiles en las Política Públicas", in José Luis Méndez, (ed.) *Organizaciones Civiles y Políticas Públicas en México y Centroamérica*, (Mexico DF: Editorial M.A. Porrúa, 1998); and José Luis Méndez (ed.), *Organizaciones Civiles y Políticas Públicas en México y Centroamérica* (Mexico DF: Editorial M.A. Porrúa, 1998).

[24] Almudena Ocejo, *Organizaciones de la Sociedad Civil, Control Ciudadano e Incidencia Política en México. Seis Casos para Entender una Práctica Heterogénea Emergente (2005-2009)*, Doctoral Thesis (México DF: UNAM, 2011).

[25] Today in Mexico there are no more than 10 organizations that consistently work on policy analysis; Fundar is one and prominently so. In terms of budget analysis at the federal level one might also mention the *Centro de Investigación y Docencia Económica* (Center for Economic Research and Teaching, or CIDE), México Evalúa, Gestión Social y Cooperación (GESOC), the *Instituto Mexicano para la Competitividad* (Mexican Institute for Competitiveness, or IMCO), the *Centro de Investigación Económica y Presupuestaria* (Center for Economic and Budget Research, orCIEP), and *Equidad de Género*: *Ciudadanía, Trabajo y Familia*. At the state level, the presence of organizations working on budget issues is even more limited: *Sonora Ciudadana* and the *Comité Promotor por una Maternidad Segura* (with presence both at the federal and state levels).

[26] See, for example, J. Chapman and Amboka Wameyo, "Monitoring and Evaluating Advocacy: A Scoping Study," Action Aid, 2001; J. Coffman, "Overview of Current Advocacy Evaluation Practice," Center for Evaluation Innovation, 2009; Jane G. Covey, "Accountability and Effectiveness of NGO Policy Alliances," *Journal of International Development*, (vol. 7, Issue 6, 1995), pp. 857-67; John Gaventa and Rosemary McGee (eds.) *Citizen Action and National Policy Reform: Making Change Happen* (London: Zed

result in progress toward that final goal and constitute an important basis for sustainable advocacy work by the organization.

As mentioned at the beginning of this document, it is very important to understand Fundar's work in the *SCyDH* initiative as a first step toward building a campaign advocacy for more effective health policy as it relates to the uninsured population. While Fundar has managed to achieve impact at the federal budget level, its most important accomplishment is the learning process that has allowed the organization to move toward achieving these goals. The results of Fundar's campaign, therefore, include both the organization strengthening for multi-level advocacy (and the transformation of the team and the organization in the process), and changes to budget policy.

After three years, the achievements of the *SCyDH* Fundar project fit into two categories:

1. *Changes in the process for publicly reporting the federal health budget aimed at the uninsured population.* Fundar played an important role in introducing seven amendments to the 2012 Federal Budget Decree. These amendments sought to improve transparency, expenditure control, evaluation, and accountability of the SP budget, in an effort to increase the legislature's capacity to supervise spending via the *Auditoría Superior de la Federación* (National Audit Office, ASF).[27] (See Table 2.)

Table 2. SP budget-related amendments suggested by Fundar and introduced in Article 44 of the 2012 Federal Budget Decree

Amendment	*Significance of the changes achieved according to Fundar*[28]
1. Annexes I, II, III, and IV of the Coordination Agreement are to be signed, if applicable, in the first quarter of the fiscal year. The CNPSS and the states will be responsible for its publication on their respective websites.	The annexes specify the obligations for implementing the Social Protection System for Health, yet they have not been published regularly to date. The annexes determine, among other things, the concepts of spending, allocation of resources, inventory of interventions, monitoring indicators of the operation, and the terms of the comprehensive evaluation of the system.
2. States must publish the total amount of funds received from the CNPSS for the purchase of medicines, distinguishing CNPSS resources from other health funding sources.	Until the adoption of the 2012 Federal Budget Decree, the states were not required to report the total amount received by the CNPSS for the purchase of medicines. The ASF's Public Accounts Audit Report of 2008, 2009, and 2010, revealed serious irregularities in the use of resources for purchasing medicines. This amendment will make it possible to monitor the

Books Ltd., 2010; Margaret Keck and Katherine Sikkink, *Activists beyond Borders* (Ithaca, NY: Cornell University Press, 1998); and Valerie Miller, Valerie "NGOs and Grassroots Policy Influence: What is success?" Institute for Development Research, 1994.

[27] The ASF is the oversight agency for the federal legislature, with a formal mandate to supervise the allocation of public resources and the implementation of public programs.

[28] Based on information provided by the *SCyDH* team.

	resources received for drug purchasing.
3. The Ministry of Health must Publish on its website the annual progress in implementing the Infrastructure Master Plan, via an indicator that measures its impact on national, state, and local medical infrastructure deficits.	Access to health services depends heavily on the availability of health infrastructure. The publication of this information will reveal whether implementation of the PMI (Infrastructure Master Plan) has an impact on gaps in the national infrastructure for meeting the population's health needs (difference between the existing infrastructure and that which needs to be built, expanded, or remodeled).
4. The CNPSS must publish biannually on its website the public works funded through resources of the *Fondo de Previsión Presupuestaria (*Provisional Budget Fund—FPP), detailing by state: 1) actual use of those resources (center, hospital or school), 2) the amounts committed, and 3) the allocation date.	Currently only the total amount of FPP resources committed by state authority is published. The remaining information is not published, and it would be relevant to do so for the public to know how resources for infrastructure are being used.
5. Annual publication by state authorities of the composition of total health spending in their state, including the proportional share of out-of-pocket spending	This would make it possible to know whether the SP is helping reduce out-of-pocket spending, and thus making public health goods and services available to the population — one of the program's main objectives. Currently, only the composition of total expenditure on health at the federal level is published. It is not possible to know the differences in health services affordability by state.
6. Federal resources transferred by the CNPSS will have to be formalized in the *Acuerdos para el Fortalecimiento de las Acciones de Salud Pública en los Estados* (Agreements to Strengthen Public Health Interventions in the States, or AFASPE), and signed in the first quarter of the fiscal year.	Currently, the AFASPE are voluntary agreements between the federation and the states. Their signature depends on the political will of the federal administration and local executives.

7. There must be an annual evaluation of the SP program by state and publication of the results on the CNPSS website. These assessments must consider indicators to assess progress in increasing: - SP beneficiaries' effective access to health services, such as interventions and medicines, contained in the Universal List of Health Services (CAUSES), disaggregated by location; - the impact on improvements to the health of beneficiaries; - the impact on economic access to health by SP beneficiaries; - actual access of women and children to health services; annd - "Healthy Pregnancy" and "Health Insurance for a New Generation," according to members' priority profile.	Currently the CNPSS creates confusion by equating access to quality goods and services with affiliation to the SP. For a more comprehensive assessment of the SP, it is important to develop evaluation tools that assess the different components that constitute effective access to healthcare: physical accessibility, availability of staff, equipment and medicines, nondiscrimination policies, quality of goods and services and their cultural adaptability, and economic affordability.

At the moment, it is too early to know how the changes in the budget reporting process will be taken into account by health agencies at the federal and state levels. However, even these changes do not guarantee improvement in states' performance in providing health services, they are a first step with important implications. Considering the current political context, in which there is neither the interest nor the incentives to introduce controls for managing the health budget, these changes help pave the way for greater SP budget transparency and accountability by the federal government and the states, as well as improvements in the evaluation of the program.[29]

According to the *SCyDH* project team, some of the most important implications of the SP budget modifications introduced include:[30]

- Reinforcing a complementary approach to public policy advocacy. Fundar's work promotes a complementary approach to public health. Since the main goal of the SP has been to achieve affiliation of the uninsured population, the mechanisms for monitoring the program have been mainly focused on reaching that goal, without considering other, more comprehensive

[29] It was not until 2008 that a specific item was introduced in the federal budget expenditures relating to the operation of SPSS. To date the guidelines in this article have remained almost entirely in place. In 2011 several points were added to increase transparency, as well as additional restrictions on the implementation of the resources associated with medicines.
[30] *SCyDH* team, interview, January 2012.

tools for monitoring the operation of the program's funding scheme and the effective provision of health services to the affiliated population. The budget modifications introduced as a result of Fundar's advocacy promote the introduction of monitoring mechanisms for transparency, control, and accountability at the budget allocation stage, allowing for progressive adjustments to budget execution as well as policy implementation.

- Increasing the information availabile on the SP budget allocation in order to strengthen the enforceability of the right to health. By introducing legal regulations to disclose more disaggregated public spending data, the program's performance is placed under public scrutiny and the gaps in healthcare funding to serve marginalized populations can be made visible. They also enable monitoring of the implementation process, the chain of responsibility, and the results obtained. This eventually can be reflected in greater enforceability of the right to health: more information means that people have the opportunity to reinforce their demand for quality care.

- Contributing to budget policy design and strengthening the formal procedures for monitoring and evaluating health expenditures. Until 2011 the Federal Budget Decree did not include mechanisms to require states to disaggregate the resources received from the CNPSS for infrastructure and medicines, and to make public information about the program. Having more information and additional evaluation criteria would allow both the legislature and the executive to know in more detail how resources are used and how health services are being provided to the population affiliated to the program.

2. *Organizational strengthening for advocacy.* In terms of the advocacy process outcomes, the team behind the *SCyDH* project today has a more sophisticated understanding of the dynamics of working with the legislature and the formal procedures to be followed for introducing budget amendments.

   They have also communicated the significance of their budget analysis more clearly, seeing it as the first link in a long chain of actions that impact the provision of public services and the right to health. That is, even though the achievements represent an advance in normative terms toward better control of the executive by the legislature and more precise monitoring of the use of public spending by other social players concerned, this only constitutes the first step. To guarantee that the regulatory changes are effectively translated into improvements in the delivery of health services, it is essential to complement the current achievements with other federal- and local-level advocacy targets and strategies, aiming for actual compliance with those regulations and for modifications in SP budget execution and operation.

How Was Impact Achieved?

The implementation of the *SCyDH* initiative posed important challenges to Fundar. Initially, the project was designed to monitor expenditure on health services and infrastructure in marginalized communities. The long-term objective was "to contribute to the improvement of health services from the perspective of the right to health, highlighting the sector's problems, specifically those related to access and availability of public health services, together with a community of practice consisting of civil organizations."[31]

[31] The description that follows is drawn from the concept note for the case study "Monitoring Healthcare Services and Infrastructure Spending in Marginal Communities," Fundar, June 2009.

To achieve this, two intervention strategies were designed for an initial three-year project phase. The first was aimed at undertaking applied research as a basis for advocacy in the legislature and the executive at the federal level. This involved generating and sharing "relevant and timely information" with key decision makers "about the shortcomings and challenges associated with the implementation of health programs and policies and their impact on marginalized communities, based on federal budget analysis results and monitoring activities at state and community level."

Initially, Fundar formed a small team for the project. It named two coordinators, each with different, complementary skills and functions within the organization (one expert on health budget analysis and the other on capacity building and technical assistance).[32] The team also included two additional members of the budget and policy analysis team, and two members of the capacity building team, for a total of six.

The first assumption behind Fundar's original strategy was that lawmakers, in spite of expectations to the contrary, are actually quite uninformed about the problems associated with the implementation of the various government programs. Therefore, sharing evidence with them on the operation of the SP would generate the interest and knowledge necessary to make the expected changes, "transforming the exercise of authority from above." The second assumption is that the improvements to budget transparency would eventually be reflected in increased access to and availability of quality health services in communities located in marginalized areas of the country.

The second strategy sought to establish a partnership with local organizations focusing on health issues in communities with a high degree of marginalization and on "supporting them in identifying problems and demanding their rights, and helping them develop skills in analyzing and monitoring public policies and budgets, and access to public information." Mexico's health system for the uninsured operates under a decentralized scheme in which the function of the SP is to fund health services while the states are responsible for providing those services through the State Health Regimes. Given this institutional arrangement, the alliance with local partner organizations could reinforce the demand for the desired changes by including not only the perspective of the SPSS budget analysis at the federal level but also some of the main manifestations of the operation of the system at local level. To build a framework for effective collaboration, and considering the need to develop competencies for budget and public policy analysis in partner organizations at the community level, Fundar would also provide local organizations with some funding and technical assistance.

As mentioned above, the first part of Fundar's strategy involved modifications at the federal budget level (to better guide budget expenditures). The responsibility to achieve this fell on Fundar itself — given its experience and track record in working at the federal level — but it would seek to incorporate the findings coming out of its collaboration with local organizations. The second strategy was associated with the operation of the SP (health service provision at local level) and involved a shared responsibility between Fundar and partner organizations, so that improvements in health budget policy at the federal level could be extended to the operation of the program at the state level.

Stages of the initiative

[32] The project design was done by Fundar´s executive director at the time, in collaboration with one of the project coordinators.

Year 1: Preparing for advocacy (2009)

The team's first activities were designed to address three fronts simultaneously: 1) conducting research to generate evidence, specifically on issues related to infrastructure and health equipment spending (construction, maintenance and renewal), and disseminating it; 2) identifying civil society organizations at the community level to monitor the provision of health services in three localities with a high degree of marginalization and to define statewide advocacy actions; and 3) identifying and approaching key advocacy targets.[33]

For the first months of 2009, Fundar focused on research on the various problems associated with the operation of the SP and the dissemination of preliminary findings through a variety of documents.[34] Simultaneously, collaborative work began with three local partner organizations, supporting them with training and technical assistance for the development of budget monitoring tools, and documenting and analyzing the problems associated with the operation of the SP in each of their communities.[35] In this first stage, the specific advocacy objectives of the project (the concrete changes that were being sought) were yet to be defined, but the initiative emphasized the need to address the shortcomings associated with lack of investment in health infrastructure. Although the project had considered both the federal executive (*Comisión Nacional de Protección Social en Salud*, National Commission for Social Protection in Health, or CNPSS) and the legislature (Chamber of Deputies) as advocacy targets, given their mandate and responsibilities for budgetary regulations and expenditures, efforts were mostly concentrated on the latter. Considering the organization's prior experience in federal budget analysis and negotiation processes, the legislature was considered a more effective starting point.

After Mexico's 2009 midterm congressional elections, the team began to formally identify key players in the new Congress. This was a major challenge, since Fundar's structure had changed, and each team of researchers would now be responsible for its own advocacy (all advocacy had previously been conducted by a dedicated team). In this transition phase, the team behind the project began to seek contact with members of the Health Committee, to share with them policy briefs on the SP. At the same time, the information was also transmitted to the Budget and Public Accounts Committee via Fundar's Legislative Monitoring Program.[36]

The proposed 2010 federal budget modifications suggested by Fundar included the following general and specific recommendations to Article 39, the federal budget article governing SPSS spending.[37]

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[33] Local partner organizations include *Asesoría, Capacitación y Asistencia en Salud, A.C.* (ACASAC) located in San Cristóbal de las Casas (Chiapasa), *Salud y Desarrollo Comunitario, A.C.* (SADEC), located in Palenque (Chiapas), and *Noche Zihuame Zan Ze Tajome, S. de SS.* (Noche) located in Chilapa (Guerrero, mountain region). The three organizations work on community health, maternal health, and women's reproductive rights.

[34] The issues addressed by the documents include the lack of investment in clinics and hospitals, and how deficits in infrastructure contributed to a limited response to the April 2009 influenza crisis in Mexico, which was exemplified by significant delays in building and equipping the *Instituto de Diagnóstico y Referencia Epidemiológicos* (Institute of Epidemiological Diagnosis and Reference, or InDRE). These documents were published on Fundar's website and distributed through its mailing list, which includes civil society organizations, academics, federal deputies, government officials, and journalists from major print media.

[35] The criteria that guided the selection of local partner organizations were twofold: 1) proven working experience on health-related issues at the local level, and 2) sustained work in and with marginalized communities. Secondary criteria also included the possibility of collaborating in the project, as well as Fundar's familiarity with the organizations.

[36] The members with whom initial contact was made were Heladio Verver (Health Committee) and Vidal Llerenas (Budget and Public Accounts Committee), both of them from the *Partido de la Revolución Democrática* (PRD).

[37] Factsheet "Public expenditure on health," November 2009; Factsheet "Out-of-pocket spending," November 2009.

General considerations:

1. To urgently address the structural failures of the health system to ensure universal health coverage (actual care, not just affiliation on paper).
2. To increase health resources – doctors, nurses, beds, clinics, and hospitals. The planned resources are insufficient to cover the current gaps in health services and to address the health needs of the population affiliated to the SP.
3. To prioritize the allocation of subsidies from *Ramo* 12 to ensure they guarantee healthcare for everyone.[38]

Specific considerations:

1. Include the following provisions:
    a. Prioritize the transfer of federal infrastructure resources to municipalities and states with greater marginalization levels and insufficient medical infrastructure.
    b. Publish the following information on the websites of the CNPSS and the Health Social Protection Units in the states:
        - criteria used by the SPSS Trust Fund for choosing public works projects;
        - catalog of public works to be financed by the SPSS Trust Fund;
        - financial information on the SPSS Trust Fund detailing the use of resources by state, center, hospital, and/or institute, and the date the resources were used;
        - out-of pocket spending as a percentage of total health expenditure; and
        - proportion of households facing catastrophic health expenditures.[39]

2. Include two indicators for monitoring and evaluating the SPSS: 1) progress in the construction of public health projects included in the Infrastructure Master Plan (PMI), and 2) impact of completed construction projects.

None of the proposals submitted were incorporated into the 2010 Federal Budget Decree.

During the second half of 2009, the team arranged three initial meetings with the federal executive, including the head of the CNPSS, the agency responsible for coordinating and supervising the operation of the SPSS at the national level.[40] While the strategy for engaging with the legislature was intended to promote discussion on the main findings of the investigation and to present proposals to modify the budget decree, the meetings with the executive in this first stage were mostly exploratory, aiming to gain insight into the operation of the SP.

At year's end, it became evident to the team that the initiative was facing difficulties. Although the first contacts had been made with the legislature and the executive, the team still needed to define specific advocacy objectives and strategies to achieve them. The budget analysis work occupied a prominent place and it was certainly the main strength, not only of the team but also of the organization, while work with partner organizations faced different obstacles. Fundar undertook a midterm assessment of the project in order to better guide the intervention, reframing its objectives, direction, and scope.

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[38] According to the administrative classification of the Federal Budget, *Ramo* 12 corresponds to federal programmable expenditures on health and includes a significant portion of resources for the operation of SPSS (SP).
[39] The SPSS Trust Fund is the agency responsible for allocating the resources earmarked for health infrastructure in marginalized areas.
[40] In April 2009 Salomón Chertorivski Woldenberg became the head of the CNPSS.

The proposed project plan and working arrangement did not seem to be functioning as designed. First, although some of the initial objectives were perfectly valid as an aspiration — such as modifying the spending patterns of health institutions, strengthening marginalized communities to demand their rights, and improving access and quality of health services — they appeared to be too ambitious and beyond the reach of Fundar and the local partner CSOs, and did not reflect what the intervention could realistically accomplish in a period of three years.[41]

Regarding the work with local CSOs, the results of the initiative appeared to be mixed. On the one hand, Fundar's initial approach to working with local partner organizations was based heavily on the use of budget analysis for the acquisition of solid evidence to advocate for changes, and this represented three major challenges: 1) coaching local organizations in the analysis of state budgets (Fundar's expertise, in contrast, involves the federal budget); 2) the incorporation of budget analysis by local counterparts as a tool to construct solid evidence — a key element of the implementation process; and 3) the limited availability of budget information at the state level compared to the federal level.

The partnership was built on the assumption that local organizations shared the goal of state budget and policy monitoring. However, even if this was agreed to in principle, the assumption did not hold up in practice. Local counterparts did consider the *SCyDH* project as complementing their own approaches to addressing local health problems and believed it would allow them to acquire alternative tools to continue pressing for the improvement of health services to the communities with which they worked. In practice though, the work with Fundar was regarded as just another way of doing things — "interesting to try and see" if it could really have an impact on decision makers' behavior and, consequently, help to modify government action — but not something they would commit to as an ongoing priority.[42]

Consequently, local partner organizations were not focusing on budget work to complement their analysis of the main problems regarding health spending at state level and its implications for service delivery. Habituated for decades to dealing with local health authorities to ameliorate health services and observing only marginal improvements dependent heavily on political interests, they remained skeptical about the benefits of budget analysis and its connection with improved health services in the short term. Their diagnosis of the problem focuses less on the need for additional budget control regulations and more on the lack of effective audit mechanisms and consequences if the SP health resources are not spent efficiently to provide health services to the targeted population groups. Additionally, working relationships appeared to be following a pattern of bilateral interactions (each of the organizations with Fundar) and not in a coalition scheme as originally intended, diminishing the effectiveness of working as an advocacy alliance; that is, sharing, complementing and reinforcing mutual advocacy efforts towarda common goal. Moreover, there seemed to be a tendency to think of the intervention as a once-off project, to be carried out within a given timeframe, rather than as offering the opportunity to develop or strengthen budget analysis and advocacy as a line of work within their own organizations.[43]

On the other hand, some very positive outcomes resulted from the relationship with local partner organizations. The most important was a modification in the project focus. While the initiative was

[41] Concept note "Monitoring Health Care Services and Infrastructure Spending in Marginal Communities,"Fundar, June 2009.
[42] Interviews with local partner organizations, April 2010.
[43] Ibid.

mainly designed to address the problem of lack of investment in health infrastructure; at the end of the first year, as a result of the collaboration with local partner organizations, the team identified more precisely some of the problems associated with the implementation of the SP in marginalized communities. As a result they decided to incorporate two additional dimensions that significantly affect the provision of health services at the local level: 1) supply and availability of medicines, and 2) out-of-pocket spending.

Year 2: Redefining and adjusting the initiative (2010)

After these adjustments were made, the dialogue with the new legislature was strengthened in 2010, specifically with the Health Committee.[44] The working relationship with the committee focused on two specific people: Deputy Heladio Verver of the *Partido de la Revolución Democrática* (PRD), one of the 11 secretaries of the committee, and Alejandro Celis of *Partido Acción Nacional* (PAN), Technical Secretary of the committee.[45] From the start, this relationship produced encouraging results, in terms of establishing opportunities for dialogue and potential collaborative work, which was reflected in the committee's readiness to jointly program a discussion forum on the subject of the right to health.[46]

The relationship with the Health Committee continued to evolve positively during 2010, unlike the relationship with the federal executive. Fundar's emerging dialogue with the CNPSS suffered a major setback. In April of that year the newspaper *El Universal* published a series of articles on the SP, emphasizing the delays and shortcomings in execution of the SPSS Trust Fund (health infrastructure resources).[47] Following one of its regular practices, Fundar briefed the newspaper on the main aspects of its SP research findings, and as a result *El Universal*'s extensive news reports included specific references to Fundar as one of its main sources of information.

Within the CNPSS, Fundar's high-profile criticism generated a negative reaction that resulted in the closing of all channels of dialogue. The perceived confrontational tone of Fundar's approach to advocacy was seen as an "attack" strategy. Policymakers claimed that it was inappropriate to use the media as a communication channel without having first tried other institutional dialogue spaces to share and discuss their data and initial findings.

According to one CNPSS senior official:

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[44] The Health Committee consists of 29 legislators: 45 percent belong to the PRI, 31 percent to the PAN, 10 percent to the PRD and the remaining 14 percent are distributed among other parties (PT, PVEM CONVERGENCIA).

[45] There are several reasons for the decision to work with these legislators. The first is that both seemed to play a leadership role in the committee. The second is that, unlike most committee members, these two showed greater openness and sensitivity to the issue of the SP. The third is that it was considered appropriate to involve various political forces in the chamber (the party of the current administration and an opposition party). Finally, a balance was sought between a political player and another that might be involved in the technical work of analyzing and drafting legislative proposals.

[46] As part of its dissemination and public awareness-raising activities, the *SCyDH* project had considered organizing an event for the national and international exchange of experiences on the right to health. Seizing the opportunity afforded by the opening of the Health Committee, the team proposed that the event be organized jointly in the framework of the 2011 budget discussion and that it should focus on the Mexican experience, ensuring an intersectoral debate that would give a voice to those who experience health problems locally. It was hoped this would allow discussion of the issue of health holistically from a rights perspective and ultimately create processes of dialogue between local social organizations, CNPSS officials, and legislators.

[47] "La decepción del Seguero Popular," Reporte Especial, *El Universal* online, 2010. Available at: www.eluniversal.com.mx/graficos/especial/EU_seguro. *El Universal* is the national newspaper with the largest circulation in the country. There are no reliable public data in Mexico on the number of copies printed by major newspapers, but according to the latest data available from the *Centro Interamericano de Marketing Aplicado* (Interamerican Center for Applied Marketing—CIMA), it is estimated that in 2001, *El Universal* printed about 170,000 copies.

> *We are working hard to reach the established SP goals and to have a better understanding of what is wrong with the program. This is a concern for all senior staff members of the SP who are in charge of running the program. . . . Fundar could accept the proposal to do something with us, even on a small scale, that way they could find out how the SP implementation is experienced in real life. . . . There are other academic organizations and institutions working on health issues with which dialogue is held with constructive objectives and positive results.*[48]

Initially, the team considered the CNPSS reaction as a positive result, as it showed that the findings of their work were relevant and had resonance among the executive. Some months later, however, given the negative implications of the media coverage for the relationship with the CNPSS, they realized it had not been as useful or effective as initially thought. From then on, and faced with the risk of jeopardizing progress toward their advocacy goals with the federal executive, Fundar opted for a lower profile in media terms and a less adversarial and more strategic approach to the CNPSS.[49] Even if dialogue with the legislature was still the main entry channel for negotiating the budget changes sought, the team recognized the relevance of the federal executive as an important player in a position to endorse or block the proposed changes in the operation of the SP in the medium and long term.

Separately, the Public Accounts Report (for the 2008 fiscal year) reinforced Fundar's position on the right to health and also the *SCyDH* team's research into the insufficient investments in infrastructure and equipment and other problems associated with the purchase of drugs. This report, produced by the ASF, included several recommendations that stressed the importance of improving the SP to ensure Mexicans' right to health. Although the inclusion of these recommendations was not the result of Fundar's interaction with the ASF, shared opinions on the problems indicated that Fundar's work was moving in the right direction.[50] Even though the working team had not considered the ASF as a potential partner, seeing the common ground they had with the ASF in the Public Accounts Report led Fundar to sieze the opportunity and seek a rapprochement with that institution specifically to monitor SP compliance with recommendations.

During the second half of 2010, the team continued to refine some of its advocacy objectives and strategies. This led to significant adjustments in the intervention and the theory of change that supports it.[51] At this time, the team decided to prioritize work on amending the SP federal budget — the budget was the component in the strategy that Fundar felt more comfortable with, had a history of institutional work with, and directly depended on the team for its completion. Meanwhile, work with local partner organizations focused mainly on the organization of the right to health forum at the legislature.

Regarding the focus on amending the federal budget, the project team established two specific budget advocacy objectives: 1) improving and strengthening transparency, oversight, and accountability mechanisms for the allocation and use of SPSS resources for infrastructure and the

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[48] Interview with a senior official of the CNPSS, February 2011.
[49] *SCyDH* team, interview, May 2011, and Juan Carlos Lavín, interview, March 2012.
[50] The three ASF officials interviewed were not familiar with Fundar's work on the SP. According to their statements, the process of reviewing the public account goes through different stages, including preparatory document review work of the various investigations undertaken by the government, academia, and other social organizations or institutions on each topic in particular. The information generated by Fundar had not been identified and, therefore, was not considered as an input for reviewing the public account.
[51] *SCyDH* Theory of Change, Fundar, November 2010.

purchase of drugs associated with CAUSES; and 2) demanding that public information be produced and published on actions and resources earmarked to address deficiencies in health infrastructure and equipment in the states with the highest degree of marginalization, as well as on the composition of out-of-pocket health spending at state and federal levels.[52]

Finally, advocacy strategies were also refined, focusing on the following actions to:

1. continue strengthening dialogue with the federal legislature (particularly with members of the Health Committee), generating political agreements and commitment to advance specific aspects of the right to health;

2. organize a forum in Congress on the universality and comprehensiveness of the right to health in the context of 2011 budget negotiations, to raise awareness of issues surrounding the public health system serving the population without social security;

3. rethink the rapprochement with the federal executive to introduce suggested improvements to the SP from a public program's operation perspective; and

4. monitor SP compliance with ASF recommendations.[53]

Starting in September, the team participated in discussions on monitoting the Federal Budget Decree. Unlike the previous year, during which a partial interaction had occurred with legislators, this time the team maintained a permanent presence in Congress, specifically in the Health Committee, highlighting the budget changes that it sought.[54] The team worked directly with Deputy Verver's staff to issue a *punto de acuerdo*, formalizing the amendments to the budget decree that had been submitted the previous year and a few additional ones related to medicines.[55] This document was sent to the Budget and Public Accounts Committee for consideration in the budget discussion.

In late September, Fundar and the Health Committee organized the forum "For a Universal and Comprehensive Healthcare" that included the participation of local partner organizations. At the suggestion of the Technical Secretary of the Health Committee, in order to obtain the legislators written commitment to work for better healthcare for the Mexican population, a document would be signed by Committee legislators at the forum's conclusion. This document was called the "Ten Commandments for Health" and the Technical Secretary helped raise the issue within the committee and negotiated with legislators to secure their signatures.[56]

However, the 2011 Federal Budget Decree again did not include the SPSS budget amendments proposed by Deputy Verver.[57] This caused consternation in the *SCyDH* team because although a

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[52] While advocacy objectives are not explicitly mentioned as such in existing documents on the initiative, it has been possible to identify them from the various objectives contained in the documents and interviews with the *SCyDH* team.
[53] Eventually, considering the level of tension between Fundar and the CNPSS, the team took the decision not to insist on monitoring the ASF recommendations in order to avoid jeopardizing the chance of further dialogue.
[54] The proposals promoted by Fundar in relation to the SP can be read in greater detail at www.las10faltantes.com/lasdiez.
[55] A "*punto de acuerdo*" is a Mexican legislative procedure that refers to the petitions presented by legislators for consideration in plenary and for the Chamber of Deputies to take an institutional position (a statement, address, or recommendation) on a nonlegislative matter. It has no binding effect.
[56] Alejandro Celis, interview, March 2012.
[57] Information Note–Positioning vis-à-vis PEF 2011 approved for Dep. 12 Health and the Social Protection System for Health, Fundar, December 2010.

good working relationship had been established with some members of the Health Committee — which is illustrated through such efforts as the joint convening of the forum and the drafting of a specific document to modify the SPSS budget — the amendments did not actually materialize, and it was difficult to identify the factors that were causing the deadlock. In addition, a genuine concern was growing among the team as to the feasibility of getting these amendments, since the next year would be the last in the terms of those legislators, so legislative work would be strongly influenced by electoral dynamics in preparation for the 2012 elections.

Year 3: Initiative consolidation (2011)

For the first half of 2011, the working relationship with local partner organizations remained quite ambiguous, with no shared advocacy objective, which contributed to making the progress of that aspect of the initiative more difficult. In response, the team continuously reflected on how to better collaborate with local partners to advance issues related to health policy and build a relationship based on the local organizations' needs and capacities without necessarily focusing on health budget analysis at the state level. After participating in the forum, the team held a follow-up meeting with the organizations to analyze the "Ten Commandments for Health" and use it as a tool to build a line of work based on its statewide dissemination. By then, however, the partner organizations were no longer working with Fundar under the initial financing and technical assistance scheme (planned only for the two initial years) and were more interested in strengthening their own agendas: working together on the *SCyDH* initiative was no longer a priority. This led the *SCyDH* team to temporarily postpone the local advocacy strategy to a later stage of a more structured campaign, once the lessons learned from this experience could be analyzed in detail to rebuild an effective future partnership.

One additional task remained to be completed — to resume the relationship with the CNPSS. The change of approach to this government agency gradually reduced the tension generated by the earlier, more confrontational approach. In early 2011, the team met with the new head of the CNPSS and outlined its main concerns associated with operation of the SP.[58] The CNPSS was willing to share information, establish future opportunities for dialogue to enrich the debate on the SP, and work in collaboration with Fundar to improve its operation. Before scheduling follow-up meetings with the CNPSS, the team decided to develop concrete proposals to improve operation of the SP and to better focus the discussion with the executive beyond exposing irregularities.

What was considered imperative by Fundar was maintaining the pressure for changes at the federal legislature, for even if 2011 was its last year in office, there was still a possibility — however remote — that the proposals might be considered. But the circumstances seemed increasingly complicated. Deputy Verver remained the main advocacy target but it was becoming evident that he was focused on pushing his own saturated agenda, in which the SP was just one of many topics. Furthermore, he seemed to have less political clout to negotiate amendments in the Budget and Public Accounts Committee than previously thought. To top it all, from late 2010 the Technical Secretary of the Health Committee (one of the team's key contacts) was no longer working in Congress.

And yet, an unexpected window of opportunity opened in the 2011 budget negotiations and Fundar managed to include some modifications in the 2012 Federal Budget Decree. Rather than leading the process of introducing amendments to the SPSS budget, Deputy Verver decided to refer the team to

[58] In September 2011 Salomón Chertorivsky, SPSS Commissioner, was appointed Health Secretary. The new Commissioner, David García Junco, had until then been the Director General for Membership and Operation of the SP.

Deputy Estela Damián, given her position as the chair of the National Audit Oversight Committee.[59] Deputy Damián considered Fundar's suggestions relevant and made a commitment to present them as part of a PRD proposal in the budget discussion. From that moment on, the team worked closely with technical advisors from the Oversight Committee. They managed to put together a proposal within one week, right before the deadline for proposed amendments to the budget. The suggested changes were structured in the format required for that purpose, clearly stating what the modifications were and justifying them in the context of the health budget policy. Deputy Damián negotiated this proposal within the CNPSS, resulting in the incorporation of the changes mentioned above (see Table 3).

After that, the team was invited to take part in further working meetings with the CNPSS to discuss issues related to transparency of the SP.[60] Including the *SCyDH* project team in these meetings is largely a response to the obligation of federal executive departments to consider public participation in accountability processes. Faced with the government mandate to incorporate participatory schemes to "improve" the operation of its programs, the departments need to identify stakeholders to enable them to meet that mandate.[61] The fact that Fundar was one of those players is indicative of the repositioning of the organization in relation to CNPSS, which at some point will enable them to build communication channels to reinforce advocacy work via the federal executive.

At the end of this case study period (March 2012), Fundar planned to strengthen and complement project activities to address pending issues, including:

1. maintaining an active presence in the legislature to identify and target the new legislators who will participate in the negotiation of the 2013 Federal Budget Decree;
2. initiating a formal dialogue with the government oversight agencies responsible for monitoring public spending, both in real time (Ministry of Public Service, SFP),[62] and *ex-post* (ASF), and establishing initial contact with CONEVAL, the department responsible for social policy evaluation;
3. resuming contact with the CNPSS to follow up on the SP budget decree modifications; and
4. redesigning the strategy for working with social partner organizations to resume the local advocacy intervention strategy that was put on hold.

[59] Two years earlier, the team had first encountered Deputy Damián to request that the ASF annual auditing program include an audit of the use of federal subsidies for the operation of the SP, which is the responsibility of the states, as well as the financial management of federal public funds transferred through the Health Services Contributions Fund and the fulfillment of goals and objectives.
[60] In November 2011 Fundar was invited to participate in the "*Ejercicio de rendición de cuentas a la sociedad sobre el Seguro Médico para una Nueva Generación"* ("Accountability Exercises – Medical Insurance for a New Generation Program, or SMNG") organized by the CNPSS. In February 2012 the team participated in a meeting with SS officials to present pro-transparency proposals for the 2012 Open Government Partnership annual meeting.
[61] These "accountability exercises" are promoted by the Ministry of Public Service (SFP), which requires departments of the federal public administration to identify areas, programs, and/or services that can boost public participation, to evaluate them and improve their management. On that basis, the department invites the few CSOs that they might know or have had previous contact with, to participate in a briefing in which some outcomes of the program or service selected for this purpose are outlined.
[62] The SFP is the federal executive department responsible for inspecting the implementation of federal spending and monitoring the management of federal public administration.

Table 3. Main changes to the 2012 Federal Budget Decree, their technical feasibility and effect on SP performance[63]

Amendments related to the SP introduced by Fundar to Article 44 of the 2012 Budget Decree	**Technical feasibility**	**Possible effect on improving budget execution and/or the provision of health services.**
Annexes I, II, III, and IV of the Coordination Agreement are to be signed, if applicable, in the first quarter of the fiscal year. The CNPSS and the states will be responsible for its publication on their respective websites.	*Medium* The CNPSS integrates the annexes and sends them to the states for their signature. Whether the annexes are signed on time depends on the information on actual affiliation provided by the states to the CNPSS. The affiliation base (information from previous year) is sent by the states to the CNPSS for the calculation of annual estimates; after that, this information needs to be checked for accuracy. Once signed, their publication should not represent an additional effort.	Greater availability of information on annual commitments to operate the SP could enable better monitoring of the program's implementation at the state level. However, the direct effect that the publication of this information might have in terms of the operation/performance of the SP is limited. The inclusion of the condition "if applicable" might open the door to noncompliance.
Publication by the states of the total amount of funds received from the CNPSS for the purchase of medicines; distinguishing CNPSS resources from other health funding sources.	*Medium* The amounts received by the State Social Protection Regimes in Health (REPSS) are clearly broken down upon arrival at the Ministries of Finance of the states. Publishing such information should not represent a major obstacle in practical terms. In is important to consider that the states do not	The irregularities detected by the ASF indicate problems associated with the implementation of drug expenditures. Once resources are received by the states, each has their own management and expenditure procedures. Therefore, publishing resources received must be accompanied by information on resources invested (when and how they were used —i.e., spending quality) otherwise it will be difficult to

[63] The analysis in this section is based on the comments made by officials responsible for implementation and follow up of the SP budget and its performance evaluation. These include the Health Ministry of Veracruz, the Ministry of Finance, the Federal Ministry of Health, and the CONEVAL (interviews, March and April 2012).

	receive the resources for each year in a single transfer. It could be more effective to plan transfers on the basis of quarterly estimates (which can be predicted) and consequently publish both the quarterly estimates and the actual funds received, according to actual changes in affiliation.	have information concerning expenditures on medicines. However, given that administrative sanctions are not effectively implemented, breaking down this information will not necessarily mean having access to "quality information" or affect the irresponsible use of public resources.
Publication on the Ministry of Health website of the annual progress in implementing the Infrastructure Master Plan, via an indicator that measures its impact on national, state, and local medical infrastructure deficits	*Low* The current description is ambiguous. "Impact on infrastructure deficits" should be clearly defined so that the agencies responsible for developing the indicators meet the requirement. Measuring "impact" within a year seems unattainable. If "impact" is understood in terms of investing where health facilities are most needed, the indicator should measure whether these new units are being built closer to the people who need them.	It would be more feasible to speak of an indicator measuring "progress" toward achieving PMI goals. This would help determine whether established infrastructure commitments are being met. Information on progress must be complemented with information about the obstacles/irregularities associated with the construction of infrastructure, as well as an explanation of why the infrastructure goal was not met and what is needed to correct that situation.
Biannual publication on the CNPSS website of infrastructure built with resources from the *Fondo de Previsión Presupuestaria* (Provisional Budget Fund, orFPP), detailing: 1) actual use of those resources by state (center, hospital, or school); 2) the	*High* The files for infrastructure approval presented to the Fund Committee contain all the information and could be made available. Once the request is presented to the Committee and approved, BANOBRAS reserves the project resources for the state.[64] The actual starting construction date is	Availability of information on the use of infrastructure resources would allow better monitoring of the construction of health facilities by the states and identify where the delays and problem areas are. This in turn would reveal if the states are meeting the commitment to build infrastructure with the resources they requested.

[64] *Banco Nacional de Obras y Servicios Públicos* (BANOBRAS) acts as the Fund trustee.

amounts committed; and 3) the allocation date of those resources.	determined by the states and it is not the same as the project approval date (there is usually a difference of several months). Resources are not transferred unless documentation proving the construction progress is filed. The allocation date refers to the initial payment, although it does not include 100 percent of the funds to be received. Records of successive payments are also included in the file.	
Annual publication by the state authorities of the composition of total health spending in their states, including the proportional share of out-of-pocket spending	*Low* The total health expenditure consists not only of data provided by the SS but also by IMSS and ISSSTE. Generating this information is a matter of complex institutional coordination within health institutions at the state level. The National Survey on Household Income and Expenditures (ENIGH) conducted by INEGI provides information on the composition of current expenditures on healthcare. The ENIGH generates information based on a nationally representative sample with a breakdown by locality (more than and less than 2,500 inhabitants). To have representative information at the subnational level the states must agree to sign an agreement for a "sample extension" to generate that information. In 2005, four of 32 states signed these agreements; in 2008 seven states did; and in 2010, only five.	It would be important to know the composition of total health spending by state, although it is not clear how that information would transform the provision of health services. Reporting household out-of-pocket spending in each state would also be important, given the SP commitment to diminish this type of expense. These data should be complemented with information about the measures being taken to diminish this expenditure for the affiliated population.

Federal resources transferred by the CNPSS will have to be established in the *Acuerdos para el Fortalecimiento de las Acciones de Salud Pública en los Estados* (Agreements to Strengthen Public Health Interventions in the States, or AFASPE), to be signed in the first quarter of the fiscal year.	*Low* The AFASPE are not the vehicle that includes the details of CNPSS resource transfers to the states; the Coordination Agreements are designed for that.[65] It is advisable to have all the information concentrated in one instrument and not multiple ones.	The direct effect that the publication of this information might have in terms of the operation/performance of the SP is not evident.

[65] The AFASPE were designed in 2007 to set aside extraordinary funding for public health actions (not covered by the SP) associated with the operation of 31 priority programs of the Ministry of Health, such as training, ambulances, hiring additional doctors, among others.

Annual evaluation of the SP program by state and the publication of the results on the CNPSS website. These assessments must consider indicators to assess progress in: - SP beneficiaries' effective access to health services, such as interventions and medicines, contained in the Universal List of Health Services (CAUSES), broken down by location; - The impact on improvements in the health of beneficiaries; - The impact of affordable access to health by SP beneficiaries; and - Women's and children's effective access to health services through the "Healthy Pregnancy" and "Health Insurance for a New Generation" strategies, according to the affiliation priority profiles.	*Low* Some progress may be achieved during 2012, especially in defining indicators. Other aspects might be less feasible since they all require significant interinstitutional coordination. It would be necessary to clearly define what type of evaluation the decree is referring to and then what is meant by "impact" on each of the items mentioned. It would also be advisable to incorporate requirements in the budget decree design and evaluation processes that consider different goals over the short, medium, and long term. Impact evaluations require an institutional planning process to design and implement a complex evaluation tool. It will be difficult to complete in one year. Moreover, 2012 is an election year and government agencies are highly constrained to do fieldwork.	

Project timeline

Date	Context	*SCyDH* Project
2001		
	SP Pilot	
2004		
	Implementation of the SP: Focus on achieving membership of the uninsured population by 2010	Research on investment in health infrastructure begins at Fundar.
2006		
	First reference to SPSS in the Federal Budget Decree, General guidelines only First ASF reports with recommendations to improve budget expenditure by the states	
2007		
		Fundar publishes "*Cinco Miradas Sobre el Derecho a la Salud. Estudios de Caso en México, El Salvador y Nicaragua*" (Five views on the right to health. Case studies on Mexico, El Salvador and Nicaragua).
2008		
	Important changes to the Federal Budget Decree: introduction of an article exclusively devoted to the SPSS The CNPSS extends the date for meeting the SP affiliation goal to 2012.	

2009		
	Midterm elections in July 2009 (total renewal of the Chamber of Deputies/governorships)	**Beginning of the SCyDH project: Year 1** First rapprochement with new legislators (Health Committee) Initially proposed changes to the CNPSS budget (these changes were not accepted). Initial work coordinating with local partner organizations Change of director at Fundar
2010		
	March: Public Account Audit Report (FY 2008). Key recommendations to advance toward a more efficient, effective, and transparent operation of the SP: - The SP is markedly inefficient in its allocation of funds from the federal government. Up to 34.5 percent of the SP resources were not spent by the states. - There is insufficient coordination between the CNPSS and the states. A mechanism for early and timely scheduling of the administration of resources is required. The Annexes included in the Coordination Agreements should be signed in December of the previous fiscal year. - Establish a maximum percentage for administrative expenses, control, and distribution of drugs in order to prevent irregularities and premium payments. Twenty-eight states purchased drugs at prices above the limit set by the Ministry of Health.	Changes in the team responsible for the project Enriched lines of research on the basis of collaboration with local partner organizations Progress in dialogue with the legislature Media exposure; dialogue with the CNPSS ceases. Organization of the forum Participation of local partner organizations/signature of the "Ten Commandments for Health" by members of the Health Committee Formal proposal for SPSS budget amendments via Dep. Verver (proposed changes to the budget level not accepted)

	- Half of the states did not provide evidence of having published semi-annual information concerning the provider's name, event bidding, and the unit cost of the drugs associated with CAUSES. Eighty-one percent of states did not provide evidence of having published quarterly monitoring and evaluation indicators to the CNPSS.	
2011		
	CONEVAL evaluates SP performance. Emphasized need to define and implement impact indicators for monitoring effective access to health services for the population affiliated to the SP. This is the last year the current legislature participates in the federal budget.	**Year 3 of the project** **First budget advocacy impacts:** Introduction of amendments to the 2012 Federal Budget Decree through Dep. Esthela Damián.
2012		
	March: Public Account Audit Report (FY 2010). Key recommendations (March 2012): - To publish at the beginning of each year the Annexes I to IV for each of the Coordination Agreements for the implementation of SPSS in the states, including the resources allocated and the allocation calendar to improve the planning, timing, and efficiency in budget execution. - Regulate the development of programs for the drug procurement process by the Health Services Regimes in the states to ensure an adequate and timely supply to meet the needs of the affiliated population, and establish the necessary	

mechanisms to monitor drug prices and purchasing processes.
- Establish performance indicators and program evaluations at the state level, in order to measure the efficiency, effectiveness, and impact of the program.
- The goal of the SP and the rest of the public health services in Mexico is to meet the universal health coverage proposed by the World Health Organization. According to the WHO it is important to provide quality access to healthcare to the entire population (including prevention, promotion, treatment, and rehabilitation) to be effective and ensuring that the use of these services does not expose people to financial difficulties. In this sense, it is not enough that people have access to health services.
- There are various budget programs focused on healthcare in Mexico, which leads to a fragmentation of services and target populations. It would be advisable to advance toward a financial consolidation of these programs, in order to create a Universal Health System in Mexico.

Why Did the Initiative Succeed or Fail?

Although a dynamic of progress and setbacks is common to any advocacy campaign, Fundar's *SCyDH* initiative illustrates the learning process involved in the development of a campaign in which the impacts achieved are the result of the interplay of external and internal factors. For example, an internal factor for SCyDH was to build advocacy capacity on several fronts, which was not fully in place when the project started.

Internal factors

Fundar's organizational learning process can be illustrated through the following examples.

1. Redefining the starting point and the objectives of the project. During the first year of implementation, it became evident to the *SCyDH* team that although the project had been conceived as a campaign, it was necessary to rethink its starting point and place the initiative in an early "construction" stage. This was principally due to two factors. The first is that compared to other advocacy campaigns on health policy in which Fundar joined a broad multisectoral effort — such as campaigns around HIV/AIDS or maternal healthcare policies — the *SCyDH* project was being built from scratch and the responsibility for its implementation lay with Fundar. This involved not only operating within an existing campaign in a complementary working dynamic but also calling on the ability to coordinate and manage the various components of a campaign as a lead organization for which no previous experience existed and, therefore, for which it was difficult to identify all the implications in advance.

   The second lesson learned is about flexibility and complexity in a campaign. The team behind the initiative began by trying to identify the problems associated with the provision of health services in marginalized communities through a program of the magnitude of the SP, involving various powers and levels of government. The first issue identified was the lack of investment in health infrastructure as one of the reasons why the insured population continued to have limited and unequal access to health services. On this basis, the original campaign objectives were proposed and local partner organizations were invited to join the initiative. However, after working with them, the team identified two additional issues associated with the provision of health services (out-of-pocket spending, and supply and availability of medicines). In positive terms, the adjustments illustrate the team's ability to fine tune the problem's dimensions and adjust the focus of the project. On the negative side, the changes introduced greater complexity (analyzing budget regulation aspects plus monitoring program operation and results).

2. Strengthening capacity for dialogue with the legislature. As mentioned earlier, in the first year of building and implementing the project, Fundar also introduced a new internal work arrangement for advocacy. Previously, a team of researchers would be responsible for generating outputs, and another team for using those outputs in budget advocacy and negotiation processes. Under the new scheme, the team responsible for each project would have to assume both tasks: research and advocacy.The *SCyDH* team had experience with federal budget research and analysis, but did not have the same experience in advocacy processes. This introduced some difficulties in moving forward with the legislators to achieve changes in the SP budget within the first two years. During this time Fundar was going through an internal reorganization process to equip those responsible for the initiative with the tools and practical knowledge that would allow a more strategic intervention.

   The learning process yielded positive results, as reflected in a more precise mapping of advocacy targets in the legislature, the individual agendas of deputies, and the balance of power both within the Health Committee and the Chamber of Deputies as a whole.[66] Although the sector-specific legislative committee was an obvious target for establishing

[66] Melissa Ortiz, interview, March 2012.

dialogue, its performance can be very mixed, depending on the political profile and clout of its members; consequently engaging this committee is not necessarily the most effective means of channeling proposals. The key lies in identifying those legislators interested in the problems associated with the advocacy project — whether or not they belong to that committee — because there is some affinity between the project issue and their own agendas or because the states they represent are particularly affected by the problem.

For the first two years of the project, dialogue with the legislature focused primarily on two members of the Health Committee. It was possible to build a profitable working relationship with them, but since they did not push the suggested amendments in the budget discussion, impact was limited. During the third year, extending the map of key players in the legislature (to Deputy Damián) resulted in additional entry points to present proposals.

In addition to refining its map of key players, the team also acquired a better understanding of the instruments and procedures for channeling formal proposals to amend the budget. The first amendments proposed by the *SCyDH* team were presented to the members of the Health Committee in late 2009, as part of the 2010 Federal Decree Budget negotiation process. However, it was not until the third year of the project that the team's continued presence in the legislature allowed it to argue and channel these proposals more strategically through Dep. Damián.

For legislature players, the different approaches between teams of professional lobbyists (private sector) and civil society organizations is clear. For the Technical Secretary of the Health Committee "this is an important factor when considering the proposals of players external to the legislature, since NGOs usually meet with us to talk, discuss, and exchange information, whereas pharmaceutical lobbyists, for example, have a permanent presence in the committee, are well aware of the procedures, and come with specific amendments drafted in the required formats. . . . This not only saves lawmakers work, as the proposals are already analyzed and justified, but they generate a lot more pressure because legislators cannot disregard them so easily."[67]

External factors

In addition to the internal factors, it is also possible to identify some important contextual factors that contributed to achieving these changes. On the one hand, Mexico has a legislative cycle maturation process that is influenced by the fact that the lower house of Congress changes every three years without possibility of re-election. Therefore, most legislators go through a learning process that significantly affects the development of any legislative advocacy initiative.

The implementation of the *SCyDH* project coincided with the start of the 61st Federal Legislature. Consequently, during the first year of the campaign the legislators were in the process of learning the dynamics of the legislature, including the balance of political forces, the decision-making process in the various committees, and the logic of budget negotiations.

[67] Interview with Alejandro Celis, March 2012.

With Deputy Verver — and the *SCyDH* project team — it was not until the second, and particularly the third year, that greater clarity about the procedures for amendments to the budget was achieved. Generally, deputies work on the development and amendment of laws, a process over which they acquire a more precise knowledge over time, since they themselves can present initiatives and have more control over them. Not so with the budget, where the Budget and Public Accounts Committee has the authority to make amendments through specific procedures that are not necessarily mastered by all legislators in their early years.[68]

In addition, although during the first two years of the project the desired changes had not been achieved, the team's sustained presence in the Health Committee ensured that Deputy Verver eventually brought the team together with Deputy Damián. Thus, this sustained presence is one of the main factors that helped Fundar achieve the transparency changes introduced by the legislature in the SP budget in the 2012 Federal Budget Decree. Without it, it would not have been possible to build a more strategic approach and seize the window of opportunity opened by Deputy Damián. Additionally, had Fundar not translated the Federal Budget Decree into concrete steps for moving towardgreater transparency in the operation of the SP, the 2012 Decree would not have considered those specific details.[69]

There are three main reasons why Fundar's budget reporting advocacy objectives were achieved.

The first was the alignment between the nature of the amendments to the SP budget suggested by Fundar and Deputy Damián's agenda. On the one hand, as chair of the Oversight Committee, Deputy Damián knew the ASF public accounts reports in detail and, therefore, was aware of the recurring problems associated with irregularities in the execution of the SP budget. On the other hand, from the beginning of the legislature and in collaboration with the executive, she had focused on achieving the introduction of more specific restrictions and controls of the states' use of federal funds. As a result of her experience and leadership on issues of accountability and her good relationship with the Undersecretary of Expenditures of the Ministry of Finance and Public Credit (SHCP), she had previously managed to include various provisions for the management of the Basic and Normal Education Contributions Fund (FAEB).[70] These intersections of agendas were the deciding factor in gaining her interest and support, since the proposals for greater SP transparency and oversight fit with her concern for improving the controls on state use of federal transfers.[71]

The second factor is related to the political trajectory of the same Deputy Damián who, besides being chair of the Oversight Committee, is also influential in the PRD Parliamentary Group. This gives her bargaining power both with members of the Budget and Public Accounts Committee (much greater than other members of her own party, including Deputy Verver), and with the federal executive, as already mentioned.

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[68] Interview with Deputy Heladio Verver, January 2012.
[69] Interviews with Deputy Estela Damián and Deputy Heladio Verver.
[70] The FAEB includes federal resources transferred to the states through *Ramos* 25 and 33. Resources must be used for decentralized care of basic and normal education needs, in accordance with Article 13 of the General Law of Education.
[71] Interviews with Congresswoman Estela Damián and Hilda Concha, March 2012.

Finally, the amendments suggested by Fundar were channeled through the formal legislative procedures for participating in budget negotiation, in which the proposed changes and their justification are explained in detail, facilitating their discussion and ensuring they are considered within the Budget and Public Accounts Committee.[72] In addition to previous work with the SHCP, Deputy Damián negotiated with her PRD colleagues on the Budget Committee to give greater weight to her proposal, which among many others included the amendments to the SP suggested by Fundar.

Further contextual factors include the repeated reporting by the ASF of several irregularities associated with the SP spending patterns since 2008, and the recommendations made by CONEVAL on the outcomes of the performance evaluation of SP.[73] Both these helped put the spotlight on the operation of the SP — more so every year — and the need to better monitor the budget execution of health resources for the uninsured, particularly by the states.

The difficulty of achieving impact during the first two years of the project were not the result of any opposition to Fundar's proposals, but rather to a certain degree of imprecision in the initial budget proposals (these were refined over the three years of the project), the low priority of the issue within the Health Committee, and to a limited knowledge among the initial advocacy targets of the dynamics and procedures for budget negotiations. Interviews with Deputy Verver and the Technical Secretary of the Health Committee do not reflect a concern for the "sensitivity" of the proposed topics, but rather a search for a balance between the multiple demands they receive from civil society organizations (including Fundar), not only in relation to the budget, but also to the approval/amendment of various laws for improving health policy. There is even some confusion about what civil organizations are "after" in participating in the budget, which is what actually generates resistance from most lawmakers. Since the budget approval process involves negotiating resources for the districts the legislators represent, civil society actors are often seen as "competition" in obtaining resources, rather than as public interest groups interested in advocating for better public spending. Legislators do not necessarily see a connection between the budget reporting goals proposed and their own interest in being able to see which districts are more or less favored by resource allocation.

An alternate reading might suggest two additional explanations for why Fundar achieved these SP budget amendments. The first one is that these were modifications that did not represent major spending restrictions for the states, especially in an election year when resources could be allocated without restraint. Consequently, there was no particular resistance to adopting them. As mentioned by a government official, this could largely be because:

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[72] Guidelines for the participation of regular legislative committees in examining and discussing the Federal Budget Decree Proposal.

[73] In 2011 CONEVAL emphasized that while the SPSS has "significantly improved the level and equity of health funding available to the uninsured population . . . the main challenge to ensuring that that the financial potential of the program will lead to significant measurable advances in effective access to quality services and in the state of health of the population, lies in the effective implementation of its resources in the health systems of the states. More information on the operation of state systems and the use of SP resources within them will be necessary" (CONEVAL, SP Performance Evaluation Report 2010-2011).

although the Federal Budget Decree is mandatory, it tends to have little resonance in the states . . . they could very well meet the requirement of publishing information and presenting periodic reports to the CNPSS on the SP budget exercise, however, that does not mean that the information is necessarily right, but in the meantime they are in compliance.[74]

In addition to the approved amendments to the SPSS budget, the proposal submitted via Deputy Damián included other changes suggested by the *SCyDH* team that were not considered. These would have introduced more specific restrictions on the use of health resources, both in regards to the purchase of medicines (i.e., requirements to provide information on the name of providers, quantity sold, sales volume, and unit cost; or the biding processes and criteria for drugs acquisition) and the investment in infrastructure (i.e., prioritizing marginalized municipalities and states and those with greatest shortage of medical units).[75]

The second explanation is that once the budget proposal is received in congress, the legislators' attention regarding the budget negotiation is mostly focused on budget increases and reallocation according to party interests, personal agendas, or the states they represent (*ampliación presupuestal*), while executive agencies are worried about what is commonly referred to as "conceding a goal."[76] In comparison, both players pay less attention to other regulatory issues, such as those related to transparency and accountability. This means that even if some of the proposed amendments could have met with resistance in the executive, they didn't because executive agencies might very well have been unaware of the proposals, only to find out about them once the budget decree was approved (or even published).[77]

Conclusions

Fundar largely carried out the *SCyDH* advocacy initiative on its own. This means that apart from their congressional allies, and possibly the ASF, there were no other players trying to influence the transparency and accountability aspects of the SP budget.

There is no doubt that by focusing on federal health budget analysis Fundar is occupying an important space, but it can also be illustrative of both the limited number of civil society organizations working in budget analysis in Mexico, and their tendency to work in silos with limited dialogue with other aspects of the budget and policy cycle (design, implementation, and evaluation). It raises the question of the sustainability of these efforts to influence the policy process, since there are few civil society actors pushing to advance these issues, as well as thin relationships between them.

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[74] Interview, April 2012.
[75] This observation is based on a comparison of amendments proposed to the 2012 Federal Budget Decree by the PRD Parliamentary Group and the changes actually incorporated.
[76] According to some of the executive government officials interviewed, executive agencies tend to be on alert because there are always budget changes introduced by legislators at the last minute and sometimes without budgetary knowledge about their implications or feasibility.
[77] As was the case with CONEVAL, who only became aware of the changes that concerned them after the decree was published.

Fundar's *SCyDH* project also highlights the difficulty faced by civil society organizations in Mexico attempting to engage in advocacy processes, both due to the incipient development of advocacy work and requisite skills within the organizations and the difficult advocacy context. The development of a new type of relationship between government and citizens in participatory processes for monitoring, analyzing, and deliberating on government performance is in its infancy. The vast majority of public institutions are not interested in opening spaces for substantive dialogue with civil society groups, and there is a resistance to broadening the processes of public decision making. On the other hand, advocacy efforts by civil society organizations are still at an early stage and are testing intervention models and strategies to open up spaces for deliberation and negotiation with the government.

This creates a vicious circle, where lack of interest among public stakeholders creates few opportunities for substantive exchanges with nongovernmental players. In turn, this constitutes an obstacle to understanding their mutual work and interests, as well as the power dynamics at play, feeding again into the lack of interest in finding common starting points for a sustained dialogue. The result is an intermittent pattern of interaction that hinders advocacy. The organizations interested in influencing public decisions face significant difficulties in terms of getting their proposals considered in the public policy decision-making process. Few policymakers consider the groups' participation in public affairs to be necessary or relevant. While civil society organizations' participation is usually a little more effective when it comes to preventing government actions, it is more difficult to position themselves as partners with the capacity to generate inputs for reforming public policy.

It is, therefore, possible to say that for now the role of these organizations in budgetary policy is still that of the "uncomfortable guest" who must be considered even if s/he is not really welcome. In their discourse, most public players agree with the importance of public participation and accountability, so it seems that by gaining visibility some organizations give the government the perfect opportunity to "consider them" and comply with the citizen participation mandate. In practice however, the contribution of civil society organizations to public policy remains marginal. In budget negotiations, what counts on the legislators' agendas are their party interests, as well as the degree of influence of various government agencies, state governments, and large private corporations. Still, if the uncomfortable guest role is the entry point for organizations to participate in public affairs, its importance should not be minimized, since it may be the avenue through which other opportunities may eventually arise.

From this perspective it is possible to identify some lessons from the *SCyDH* project that can serve as a reference point for organizations interested in influencing budget negotiation processes in Mexico.

The first is that the annual nature of the budget cycle and the limited time that legislators remain in office (three years without re-election) involves intensive technical advocacy work. Every three years organizations have to rebuild the relationship with legislators from scratch. This means that the possibilities for influencing the legislature tend to increase toward the end of each term, while the first year is usually an exploratory stage

Second, it is important to highlight the cumulative nature of advocacy work. Even if initially the advocacy campaign is not fully defined, advocacy activities can establish inroads that can lead to new opportunities to introduce the desired changes, even without having sought them intentionally. Therefore, in uncertain advocacy contexts in which intermittent dynamics with public players prevail, it is crucial to sustain follow-up work on the various advocacy channels identified throughout the project's life, not only to exploit unexpected windows of opportunity but to consolidate the relationship with those key players with the authority to make the desired changes. In the case of the *SCyDH* project, although the initial approach to Dep. Damián in the first year of the legislature had no major consequences and the team had not been proactive in strengthening the relationship, when Deputy Verver facilitated a new approach in the third year, the fact that the team was not entirely unknown to her helped facilitate the dialogue. In retrospect, given the alignment of agendas between the *SCyDH* project and the deputy, closer work with her from the beginning might have allowed the team to move forward more strategically and explore ways of achieving further impact, i.e., by establishing additional pressure channels through the ASF and the SHCP.

A third lesson is the relevance of designing in advance differentiated communication and media strategies for different audiences. In Mexico, civil society organizations tend to associate media presence with exposure of irregularities or deficiencies in government (public complaint). However, media exposure should be approached with caution, since its effectiveness as a pressure mechanism might not be automatic. Its usefulness can vary, depending on the objectives of each campaign or phases of it, the player addressed, and the political context. The experience of the *SCyDH* project illustrates how questioning an executive agency, through the media, without having explored or exhausted other institutional channels, might provide an ideal excuse for government institutions to close opportunities for dialogue.

Finally, the task of building an alliance or coalition for advocacy that combines federal and local actors requires a large time commitment and significant coordination and negotiation skills. The decision to build an advocacy campaign in collaboration with local CSOs on this project was a first for Fundar, and the experience shows that traditional think-tank policy and advocacy organizations — especially those focused mostly on the federal level — face substantial challenges in taking alternative approaches that incorporate community or locally based interventions to complement and strengthen their advocacy working model.

Fundar's relationship with local partner organizations undoubtedly enriched the initiative's focus, providing additional aspects to consider in the analysis of health services to marginalized communities (e.g., availability of medicines and out-of-pocket spending). Beyond exposing particular irregularities in the provision of health services in each community, a collaborative scheme with shared advocacy objectives at the state level has yet to be developed. Since the problems with the SP operation are strongly associated with the provision of healthcare services at the state and municipal levels, it might be neccessary to rebuild a formal alliance with local organizations to complement the advocacy results achieved at the federal level.

The changes achieved by Fundar constitute a first step toward advancing transparency in the SPSS and strengthening its oversight and evaluation mechanisms by the federal legislature. Nevertheless, budget advocacy work in Mexico has limitations in its effect on improving

institutional performance. In this case the regulatory provisions in the federal budget do not immediately translate into improved quality of SP expenditures, or into increased availability and access to healthcare, because its implementation depends mostly on the State Health Regimes, where the main problems currently exist. This is important because the inefficient formal oversight system hinders the accountability cycle, i.e., noncompliance with regulations or inefficient program implementation is not appropriately sanctioned. As Kenney argues, "the powers on which accountability depends often fail to act."[78]

When the formal oversight and accountability system does not work properly, government agencies and states lack the incentives to fully comply with the regulations established in the budget decree. A state government official clearly reflects the obstacles associated with the monitoring of public spending in Mexico, saying:

> *The final ASF report is very convincing, highlighting once more the underspending and discretionary management of the SP resources. And yet nothing happens. . . . If there is no administrative sanction, the budget may be better earmarked and broken down, but at the state level this does not lead to a real change. The fundamental issue is the lack of sanctions . . . the budget decree is an imprecise tool with many opportunities for improvement and more accurate earmarking requirements. However, it is unlikely that changes in the Federal Budget Decree would have a statewide impact on the efficiency of programs. In that sense it is of limited relevance. . . . Discretionary use of resources is nothing new. Although budget transparency is important because it allows better monitoring and analysis of how resources are used, in terms of improving management there is not such a clear relationship. Greater transparency allows knowing what is happening to some extent, but nothing more. What is needed is to spend the resources in a timely manner. Civil society initiatives need to promote a more effective sanction system when irregular or inefficient spending takes place.*[79]

On the other hand, civil society organizations doing budget analysis operate within a landscape marked by a significant lack of information exchange and uncoordinated work between the legislators and the various stakeholders affected by or involved in the operation of a program or policy. Limited, unilateral, or partial knowledge of budget regulations by the relevant stakeholders may lead them to propose and approve provisions with limited technical feasibility, resulting in budget regulatory noncompliance. One should question whether this is only due to inefficiencies or irregularities, or because the regulations contain requirements impossible to fulfill within the short-term horizon of the budget decree.

Civil society organizations interested in influencing health budget policy involving different branches and levels of government face some major challenges to ensure that changes to the budget level have specific impacts on spending behavior and on the provision of healthcare services. The main challenge is to identify the various links in the decision-making chain that tie the budget to the provision of quality health services, in order to strengthen different complementary advocacy fronts. A second challenge is to find a better balance between budget analysis and advocacy at the federal level with strategies aimed at the executives and legislatures at the state level, as well as at formal oversight, accountability, and evaluation agencies within government departments.

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[78] Charles Kenney, Charles "Horizontal Accountability: Concepts and Conflicts," in Scott Mainwaring and Christopher Welna (eds.), *Democratic Accountability in Latin America* (New York: Oxford University Press, 2003), p. 65.
[79] Interview, April 2012.

A third challenge is the need to ensure the technical feasibility of any proposed budget amendments, otherwise civil society organizations might be contributing inadvertently to fueling the dynamic of "minimum compliance."

Finally, since the impact of civil society advocacy work on public services depend largely on the proper functioning of the legal system to effectively sanction irregularities in the exercise of public spending and/or government performance, it might be relevant to explore the suitability of broadening current advocacy work to transform public accountability mechanisms (including enforcement) at the federal, state, and municipal levels.

Annex 1: Acronyms

ASF	*Auditoría Superior de la Federación* National Audit Office
CAUSES	*Catálogo Universal de Servicios de Salud* Universal List of Health Services
CNPSS	*Comisión Nacional de Protección Social en Salud* National Commission for Social Protection in Health
CONEVAL	*Consejo Nacional de Evaluación de la Política de Desarrollo Social* National Social Policy Evaluation Commission
CSO	civil society organizations
FASSA	*Fondo de Aportaciones para los Servicios de Salud* Health Services Contributions Fund
IBP	International Budget Partnership
IMSS	*Instituto Mexicano del Seguro Social* Mexican Institute for Social Security
INEGI	*Instituto Nacional de Geografía e Informática*
ISSSTE	*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* Institute for Health and Social Security for Government Workers
PAN	*Partido Acción Nacional*
PMI	Infrastructure Master Plan
PRD	*Partido de la Revolución Democrática*
PRI	*Partido Revolucionario Institucional*
REPSS	*Regimenes Estatales de Protección Social en Salud* State Regimes for Social Protection in Health
SCyDH	*Salud, Ciudadanía y Derechos Humanos* Health, Citizenship and Human Rights Project
SHCP	*Secretaría de Hacienda y Crédito Público* Federal Ministry of Finance
SP	*Seguro Popular* Popular Insurance Program
SPSS	*Sistema de Protección Social en Salud* Social Protection System in Health
SS	*Secretaría de Salud* Federal Ministry of Health

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Annex 3: Interviews

Internal

1. Briseida Lavielle, researcher, Budget and Policy Analysis Area, member of the *SCyDH* team
2. Gina Chacón, researcher, Budget and Policy Analysis Area, member of the *SCyDH* team
3. Mariana Pérez, researcher, Budget and Policy Analysis Area, member of the *SCyDH* team
4. Miguel Pulido, Executive Director
5. Melissa Ortiz, Researcher, Legislative Monitoring and Liaison Program
6. Juan Carlos Lavín, Institutional Communications Coordinator

External

1. Deputy Heladio Verver, Secretary of the Health Committee, Federal Chamber of Deputies, LXI Legislature (2009-2012), PRD
2. Deputy Esthela Damián, President of the National Audit Office Oversight Committee, Federal Chamber of Deputies, LXI Legislature (2009-2012), PRD
3. Alejandro Celis, Former Technical Secretary of the Health Committee, Federal Chamber of Deputies, LXI Legislature (2009-2012), PAN
4. Hilda Concha, Technical Secretary of the National Audit Office Oversight Committee, Federal Chamber of Deputies, LXI Legislature (2009-2012)
5. David García Junco, Head of the National Commission for Social Protection in Health (CNPSS)
6. Chief of Staff, National Commission for Social Protection in Health (CNPSS)
7. Javier Pérez, Special Auditor for Financial Compliance, National Audit Office (ASF)
8. Juventino Pineda, Special Auditor for Federal Resources Spending, National Audit Office (ASF)
9. Marisela Márquez, General Director for Social Development Performance Audits, National Audit Office (ASF)
10. Thania de la Garza, Evaluation Director, National Evaluation Council (CONEVAL)
11. Director of Budget Programming and Integration, Federal Ministry of Health (SS)
12. Director of Budget Programming, Health Sector, Federal Ministry of Finance (SHCP)
13. Head of Training and Development in Maternal Health Department, Ministry of Health, Veracruz
14. Emanuel Orozco, Researcher, National Institute of Public Health (INSP)
15. Eva Sántiz, Asesoría, Capacitación y Asistencia en Salud A.C. (ACASAC), Local partner organization.
16. Ángel Gómez, Asesoría, Capacitación y Asistencia en Salud A.C. (ACASAC), Local partner organization.
17. Joel Heredia, Salud y Desarrollo Comunitario (SADEC), Local partner organization.
18. Luis Adrián Quiroz, Founder and Executive Director, DVVIMSS/Salud, Derechos y Justicia A.C., Member of the Health Access Network