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Social participation and quality of health care: the experience of citizens' health representatives in Mexico

ABSTRACT

OBJECTIVE: This article describes the experience of the *aval ciudadano* "Citizens' Representative" (CR) in improving the Mexican health care system.

METHODS: This is a qualitative study which took place in eight Mexican states in 2008. It evaluates different aspects of a nationwide program to increase the quality of health care services (National Crusade for Quality in Health Services). The Mexican strategy is compared with experiences in other Latin American countries.

RESULTS: In this paper, there is the description of achievements and problems encountered by the CR in promoting social participation in the health of the population.

CONCLUSIONS: The CR has great influence when representing health service users and passing on their demands for improvements to health care quality.

DESCRIPTORS: Quality of Health Care. Social Participation. Qualitative Research.

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INTRODUCTION

The creation of the CR (*Aval Ciudadano* - Citizens' Representative) is an institutional strategy for social participation in health care in Mexico, designed to increase confidence in public and private institutions on the part of their users. The strategy was implemented in 2001 as part of the CNCSS (*Cruzada Nacional por la Calidad de los Servicios de Salud* - National Crusade for Quality in Health Services) framework aiming to improve the quality of health care services. The CR may be an individual, a group or an academic institution which undertakes the monitoring of the process of improving health care services.^a They are chosen according to recognition and social prestige in the local context, to act as a guarantor of a good health care service. Currently, the CR is connected to the process of implementing the SPSS (*Sistema de Protección Social en Salud* - Social Protection in Health System)^b which is a descendant of the health reforms that began in Mexico in the 1980s leading to its creation in 2003.¹⁸

The Popular Insurance scheme was designed as a voluntary scheme financed from three sources: a) federal; b) state and c) family. The federation transferred economic resources to the states, which were then responsible for providing part of the financing to guarantee the provision of a package of services for 277 medical procedures.^c The *Fondo de Protección Contra Gastos Catastróficos* (Fund for the Protection against Catastrophic Expenditures) is a fund which covers the provision of high cost procedures which require highly specialized hospital care. Families are charged to become part of the SPSS, however, those in the lowest income bands (95% of the affiliated population) are exempt from paying.

In order to receive resources from the Popular Insurance, health care units need to go through a process of accreditation, which consists of verifying capacity, security and quality of the care provided, as well as having a CR.^d Ideally, the CR guarantees that care provided will be permanently under scrutiny, seeking to inform members of their rights as service users in both senses: as a civil right and also as their right to the specific medical care that SPSS provides to its members.^e

This interest in protecting the citizen is expressed in a capitated financial allocation logic that seeks to replace

“supply subsidies” by “demand subsidies”, theoretically allowing patients to increase their capacity to decide which type of health care provider they prefer. This scheme assumes the user is informed and able to express an opinion and that there is a financial allocation agent capable of responding to their expressed needs.

The 2010 WHO World Health Report,¹² concluded that the mechanisms which would make universal cover possible in low- and middle-income countries is social participation in a pre-pay scheme. The 2008 report¹³ indicated that countries' delays in driving forward public policies which favored the population and health care sector cooperation was one explanation for inequalities in this area. Similar recommendations have been made since the Alma-Ata declaration in 1978.¹⁴

There are various reference frameworks on social participation or citizenship and quality health care.^{3,8,10,15,16,22} The first concept of this investigation falls within the health promotion framework, which incorporates the APS strategy *Atención Primaria a la Salud* - Primary Health Care. The population should voice their opinions on medical care received in order to create a better atmosphere, aimed at fostering quality of life for the users.^f De Roux⁴ describes four different types of social participation: collaboration, co-management, self-management and negotiation. Collaboration refers to people and health activities coming together to help achieve goals. Co-management requires a greater intervention on the part of the population in making decisions and, therefore, a greater degree of participation and democracy. Self-management is a more independent form of actions being carried out, encouraging processes leading to autonomy, without governmental support. Negotiation occurs when participation is promoted by the state due to the requirement for constant dialogue between the demands of the population and the responses of the institutions.

Donabedian^{5,6} distinguishes three relevant aspects for guaranteeing quality medical care: a) technical resources; b) the physical environment in which the care is provided and c) interpersonal relationship management. This investigation sought to generate evidence to answer the question of whether the type of citizen participation, encouraged to include the CR in

^a Secretaría de Salud. Programa Nacional de Salud 2001-2006. Programa de Acción: Cruzada Nacional por la Calidad de los Servicios de Salud. México (DF); 2001 [cited 2012 Feb 18]. Available from: http://www.salud.gob.mx/docprog/estrategia_4/cruzada_nal_salud.pdf

^b Secretaría de Salud, Comisión Nacional de Protección Social en Salud. Seguro Popular. México (DF); 2013 [cited 2013 Feb 18]. Available from: <http://www.seguro-popular.salud.gob.mx>

^c Secretaría de Salud, Comisión Nacional del Sistema de Protección Social en Salud. Seguro Popular: catálogo universal de servicios de salud 2010. México (DF); 2010.

^d Secretaría de Salud, Comisión Nacional de Protección Social en Salud. Programa de Acción Específico: Sistema de Protección Social en Salud 2007-2012. México (DF); 2007.

^e Secretaría de Salud, Comisión Nacional de Protección Social en Salud. Carta de derechos y obligaciones de los afiliados al Seguro Popular. México (DF); 2009.

^f Organización Panamericana de la Salud. Carta de Ottawa para la promoción de la salud. Washington (DC); 1986.

monitoring the quality of care provided in the units is oriented towards co-management/self-management or whether it is targeted only at cooperation with health care services without a critical perspective of its performance. In other words, whether social participation via the CR works to guarantee the quality of medical care or whether it is, on the contrary, a guarantee of legitimacy of a policy supporting a health care program.

The objective of this article is to analyze the experience of the citizens' representative in improving the quality of the services in the Mexican health care system.

METHODS

A qualitative-interpretative study was carried out. Data collection investigated experiences by understanding the narratives of subjects.^{19,20} The data were collected throughout 2008 in eight Mexican states. The health care units observed were health centers which provided ambulatory primary care. Two units per state were chosen, in both rural and urban areas, one of which was accredited and the other not, in order to compare units which had a CR with those which did not.

Primary sources of information were preferred. In each center, three types of interviewees were chosen, who reported their own experiences at the level of analysis sought: a) Citizens' Representatives; b) Health care staff and c) users affiliated to the Popular Insurance and other non-affiliated users, which corresponded to the affiliated and non-affiliated centers respectively.

Three techniques were used to collect data: semi-structured individual interviews (with doctors and nurses at the health centers), group interviews (with users of the health care units) and non-participant observation. For each technique there were interview and observation guidelines.

In total, 16 health centers were visited. Eight Citizens' Representatives, 14 nurses and four doctors were interviewed. Eight health care service users participated in 16 group interviews. Sixteen non-participant observation reports were drawn up.

The interviews were recorded, with the participants' permission. These recordings were transcribed and turned into text archives. The data collected were analyzed using discourse analysis.²¹ To do this, a list of thematic categories was drawn up, from which matrices of concentrated data were created for each level of analysis.

In order to interpret the findings, categories were constructed. For the CR: CR profile; role in the health center; role in the care unit. For the users: user profile; significance of care quality; common problems in the health center; participation mechanisms. For the health

care personnel: opinions on the CR participation; difficulties in providing better health care. Complementary to these testimonials, the non-participant observation also used categories to assess the dynamics of the care unit: infrastructure; users' treatment by the health care personnel; number and type of human resources.

All ethical aspects of research using humans were observed, fulfilling the norms set by the Declaration of Helsinki. The design of the study was approved by the Instituto Nacional de Salud Pública Ethics Committee for Research and Bio-security on 25th October 2007.

RESULTS

CR have a diverse background. In the rural areas they were housewives with elementary education on average, with previous experience of community participation and noted for taking part in various health committees. The CR in urban areas tended to have a higher level of education.

There were three ways in which a CR would be appointed to the post: voluntary participation, nominated by health care personnel and by inter-institutional agreement. In the first case, the CR decided to take part in the project of improving the care unit and took on the task because of their conviction that the care provided to the users needed to be improved. In this way, the CR in Veracruz and Zacatecas could be found in rural, non-affiliated health care units who technically should not have had a CR, but where the CR nevertheless informally participated in training for the accreditation process. Those CR nominated by health care personnel were the majority (four), two in rural areas and two in urban areas. These were less active than the volunteers. Appointing CR by inter-institutional agreement was an advanced form of appointment concerning the contributions of academic institutions to fulfill the role of observing best practice within the state's health care system. This was the case in the states of Chihuahua and Sinaloa (Tables 1 and 2).

The functions and activities corresponding to the CR performance were: carrying out regular surveys to assess user satisfaction with the health care services provided, listen to patients' suggestions and detect deficiencies in the health care units' infrastructure through a suggestions and complaints box, draw up an annual plan of work, coordinate activities with other CR in the state, disseminate NCQHS strategies and promote patients' rights.

The way these tasks were performed was according to the abilities and resources of each CR. In the majority of cases, they dedicated themselves to seeking user cooperation in evaluating the health care services through a suggestions and complaints box located

Table 1. Investigation of the urban area: Baja California Sur, Sinaloa, Durango, Estado de México, 2008.

Type of interviewee	Type of unit	Individual interviews CR	Group interviews	Observation reports
Citizens' representative	Accredited Health center Urban area	4	-	-
	Accredited Health center Urban area	6	-	-
Health care personnel	Accredited Health center Urban area	4	-	-
	Accredited Health center Urban area	-	4	4
Popular insurance members	Non accredited Health center Urban area	-	4	4
	Non accredited Health center Urban area	-	4	4
Total urban area		14	8	8

CR: Citizens' representative

Table 2. Investigation of the rural area, states: Chihuahua, Veracruz, Zacatecas, Guerrero, 2008.

Type of interviewee	Type of unit	Individual interviews CR	Group interviews	Observation reports
Citizens' representative	Non accredited Health center Rural area	4	-	-
	Accredited Health center Rural area	4	-	-
Health care personnel	Non accredited Health center Rural area	4	-	-
	Accredited Health center Rural area	-	4	4
Popular insurance members	Non accredited Health center Rural area	-	4	4
	Non accredited Health center Rural area	-	4	4
Total rural area		12	8	8

CR: Citizens' representative

within the unit. The range of their activities depended on their own initiative, rather than on planned actions, the health care units did not have sufficient economic resources to support these activities. The work of the CR depended on the individual's level of commitment to the role.

Among the main challenges to better functioning faced by the health care units were: shortages of medications in both accredited and non-accredited units, resistance to change on the part of the staff (particularly doctors), deficiencies in infrastructure and distrust towards health care personnel (Table 3).

The profiles of users who took part in the group interviews coincided in two main common characteristics: a) almost all of them were affiliated to the SPSS and b) the health center was their only option for health care. The average number of participants per group was five, the majority women aged between 18 and 60. Those with the lowest levels of education had not finished primary school, those with the highest level had studied at university. Users in urban areas had higher levels of education compared to those in rural areas. Users agreed that quality care consisted of 'being well-treated, health care personnel providing explanations about the illness, knowing the treatment to be given and being seen in tidy facilities'.

Table 3. Difficulties for the proper functioning of health centers in eight Mexican states, 2008.

States	BCS	Sinaloa	Durango	México	Guerrero	Chihuahua	Veracruz	Zacatecas
Type of unit	UHC	UHC	UHC	UHC	RHC	RHC	RHC	RHC
Categories	A	A	A	A	NA	NA	NA	NA
Resistance to change and to involvement in care quality actions by medical and administrative staff	X		X					
Medical staff not treating the users well	X		X				X	
Insufficient supply of medicines				X			X	X
Poor infrastructure in health centers	X	X		X				X
Users distrustful of 'free' health care				X	X			

UHC: Urban health center; RHC: Rural health center; A: Accredited; NA: Non accredited

Participants from urban areas indicated that a common problem in the health centers was long waiting time, lack of medicines and lack of services, for example dental health services. The most common difficulty reported in rural areas was the lack of adequately trained personnel. Another frequent complaint was the lack of accessible laboratories, which meant additional unforeseen costs for them.

On the subject of participation mechanisms in the urban environment, half of the interviewees agreed that there was a complaints box in their care unit, but were unaware of the mechanisms for using it. In the rural areas, almost all of the interviewees reported they were unaware of the strategy for improving health care quality and the possibility of using a suggestions/complaints box.

Health care professionals who work in accredited health centers in urban areas reported that CR collaborated in conducting satisfaction surveys with users, which helped to monitor quality in the services. However, they were unaware of the CNCSS strategy and did not indicate how it would benefit the care unit in the future.

“... I feel that there has been positive change; before, the patients did not know their rights. In cases of negligence they did not know how to complain; before the indigenous were not well treated, and now this doesn't happen...” (PS, EdoMex-UA)

The interviewees in the non-accredited health care units reported difficulties finding collaborators willing to act as RC among the users, and complained of the rural populations' lack of participation.

In both urban and rural contexts, lack of training on quality of care, inadequate human resources in the

medical unit and the deficiency in the units' infrastructure were the main obstacles to providing the highest quality care. The nursing staff agreed on the need for their work to be recognized, which motivates them to improve. They also emphasized frequent rotation of doctors, lack of proper equipment and medicine shortages.

The accredited health care centers had better infrastructure than those which were not accredited. There was an important difference between those in urban and those in rural zones in terms of services provided. In the former, there were more doctors and more specialties such as gynecology, dentistry and pediatrics. In the rural context, only one unit which had two doctors was identified, where only preventative medicine was practiced. In the unaccredited units, it was possible to verify lack of medicines, curative materials and other basic equipment for treating users in the pharmacies.

It was verified that the patients were well treated, although subtly coercive behavior was observed when users were asked to collaborate with the care unit. In the urban area one health center was found which had 31 doctors and 40 nurses, whereas in rural areas the average was two doctors.

DISCUSSION

The limitation of scope in this analysis is common to all qualitative studies, and is related to the restricted sample of federal entities (8) and health care units (16) which do not represent the role of CR in the whole country. Interviewees were selected based solely upon the identification of their role in activities related to the CR. This may have introduced biases in interpretation, which we sought to control through triangulated interpretations of the interviewees' versions.

Table 4. Experiences of social participation according to purpose, in Brazil, Colombia, Chile and Mexico, 2008.

Country	Form of organization	Profile of user	Functions	Types of participation promoted according to De Roux
Brazil	Collective intermediary	Users with capacity for political negotiation	High involvement, even in spending	Negotiation
Colombia	Individual	Dissatisfied user	Legal protection for users	Not typified
Chile	Collective intermediary	Users with capacity for negotiation	Consultations with management	Negotiation
Mexico After the CNCSS	Individual/collective intermediary	Informed user	Improve quality of care	Collaboration

CNCSS: *Cruzada Nacional por la Calidad de los Servicios de Salud* (National Crusade for Quality in Health Services)

The type of social participation which has been encouraged by the CR strategy corresponded to the collaborationist category. The figure of the CR legitimizes governmental action and is focused on not seeking social action, in order to improve the quality of health care. In order to reach an ideal level of citizen empowerment, CR should be equipped with previous experience of participation, and participate voluntarily. They should also gain independence with respect to health care personnel, which would provide them with greater autonomy to develop and carry out their activities within the health care unit. Their success should not depend solely upon their personal abilities, social skills and commitment, but rather upon the ability to coordinate the work of all involved in order to improve levels of care for the users.

Another example of best practice which should be promoted is the nomination of CR by inter-institutional agreement: institutional CR have more autonomy, which provides those who observe health care performance with more certainty. Nominations of CR by health care personnel should be phased out, as they are obliged to occupy a position rather than decide it by themselves. This predisposes performance and restricts the autonomy they may have to give their opinion on the quality of health care provided in the health care unit.

Accrediting units means better infrastructure, but does not always increase the quality of health care. For *Popular* Insurance members, accreditation is not a guarantee that they will receive better care.

It is necessary that health care personnel are made aware of the importance of the CR in relation to the health care unit's accreditation. Health centers' needs vary depending on whether they are located in urban or rural areas. There are some quality issues which

exist in both contexts (for example, waiting times, the way the patients are treated and lack of medicines), but others (such as lack of specialist care) are related to the unit's geographical location. The disparities observed between urban and rural contexts explain users' complaints about long waiting times and nursing staff comments on the need for their day to day efforts to be recognized.

Such differences should not exist if the units are accredited and equipped to provide the medical procedures included in SPHS affiliation. Resources obtained through accreditation should be focused on resolving the needs indicated by the users.

In Latin America, experiences of social participation have been varied. Design and implementation of programs depend largely upon the social and political values of each country.^{1,7,11,17} Over the last few years, the majority of reforms in the field of health care have in reality encouraged the participation of covered populations as individual users rather than as a collective, negotiating entity, even when the promotion of social inclusion was included in the mission statement.²

Some representative cases which can be compared to the Mexican model are those of Colombia, Brazil and Chile (Table 4).

In the health care system in Colombia, they have sought to relate social participation with quality of health care services. The 100 Law, which led to reform in the health care system, includes the right of the citizen to participate in health care decisions and created channels for the citizens to complain if they were dissatisfied with the care received. These channels are operated through the legal system and the complainant is given legal protection, which has

become an element in the national debate as regards its role in guaranteeing users' rights.⁸

In Brazil, the social movement which gave rise to the creation of SUS (National Unified Health System) was a widely representative campaign in favor of creating democratic action.²³ Within the design of the SUS, the creation of Health Councils at different levels of the structure sought to guarantee the representation of the interests of all parties. The councils participate in all types of decision, including those related to spending.⁹ The type of participation seen in Brazil is most similar to the negotiation model.

In Chile, the Ministry of Health set three proposals into action in order to create the "social participation in the health sector network" in 1995. One of those led to the creation of Development and Advice Councils, which was an effort to institutionalize participation in health care management. These are examples of communication with hospital management and primary care doctors. They are made up of user representatives, local community organizations and health workers.

The proposal to create and define the functions of CR in Mexico is a step forward in the institutionalization of social participation in health, as it reveals the strategic importance of promoting the users' perspectives in order to improve the quality of the services. The citizen component opens a path of communication

between personnel in the health centers and users and encourages citizen participation.

The health centers improved their infrastructure as a result of implementing CNCSS, especially those which were accredited. Although in reality there are still difficulties, with health care units in rural areas being most affected. In some states, and particularly in urban areas, the CR has functioned as a mechanism to incorporate citizen representation. However, their ability to influence aspects which impact on the users' perceptions of care quality is dubious. For example, insufficient supplies of medicines and the availability of more human resources.

In spite of the deficiencies, the very existence of the CR is an important step towards the goal of citizen participation in health and in improving health care quality. This should be strengthened so that, ultimately, a type of citizen participation which is less collaborative and more negotiated can be achieved, something which until now has not been sufficiently promoted in Mexico. There is a need to encourage change in health care workers' attitudes in order to increase the public's confidence in health care services, to encourage user organization in such a way that the CR has the capacity to fully represent the citizenry and to generate incentives to perform the CR activities in the health care unit.

⁸ Celerón C, Noé M. Participación y gestión en salud. En: Centro Latinoamericano de Administración para el Desarrollo. Hacia la implantación de modelos de administración gerencial en salud pública: 12. Concurso de Ensayos del CLAD, ensayos premiados. Washington (DC): OPS; 1999.

REFERENCES

1. Abrantes Pêgo R. Participación social en salud: un estudio de caso en Brasil. *Salud Publica Mex.* 1999;41(6):466-74.
2. Cardaci D. Promoción de la salud: ¿Cambio cultural o nueva retórica? En: Bronfman M, Castro R, coordinadores. *Salud, cambio social y política: perspectivas desde América Latina.* México (DF): EDAMEX; 1999. p.403-413.
3. Arroyo Hiram V, Cerqueira MT, ed. *La promoción de la salud y la educación para la salud en América Latina. Un análisis sectorial.* San Juan, Puerto Rico: Organización Panamericana de la Salud/UIPES/ Editorial de la Universidad de Puerto Rico, 1997.
4. De Roux GI. Participación y cogestión de la salud. *Educ Med Salud.* 1993;27(1):50-60.
5. Donabedian A. Continuidad y cambio en la búsqueda de la calidad. *Salud Publica Mex.* 1993;35(3):238-47.
6. Donabedian A. La dimensión internacional de la evaluación y garantía de la calidad. *Salud Publica Mex.* 1990;32(2):113-7.
7. González Fernández MI, Orozco Núñez E, Cifuentes E. Análisis político del Programa de Control del Dengue en Morelos, México. *Rev Saude Publica.* 2010;44(6):1079-86. DOI:10.1590/S0034-89102010005000040
8. Hufty M, Báscolo E, Bazzani R. Gobernanza en salud: un aporte conceptual y analítico para la investigación. *Cad Saude Publica.* 2006;22(Supl):S35-45. DOI:10.1590/S0102-311X2006001300013
9. Labra ME. Capital social y consejos de salud en Brasil: ¿un círculo virtuoso? *Cad Saude Publica.* 2002;18(Supl):S47-55. DOI:10.1590/S0102-311X2002000700006
10. Landau M. Cuestión de ciudadanía, autoridad estatal y participación ciudadana. *Rev Mex Sociol.* 2008;70(1):7-45.
11. Martínez-Hernández A. Dialógica, etnografía e educação em saúde. *Rev Saude Publica.* 2010;44(3):399-405. DOI:10.1590/S0034-89102010005000016
12. Organización Mundial de la Salud. Informe sobre la salud en el mundo 2010: la financiación de los sistemas de salud, el camino hacia la cobertura universal. Ginebra; 2010.
13. Organización Mundial de la Salud. Informe sobre la salud en el mundo 2008: la atención primaria de salud, más necesaria que nunca. Ginebra; 2008.
14. Organización Mundial de la Salud, Organización Panamericana de la Salud. *Declaración de Alma-Ata: atención primaria de salud.* Ginebra; 1978.
15. Paz MF. Participación en la gestión y evaluaciones sociales. Tensiones de la gobernanza en el México rural. *Polit Cult.* 2008;(30):193-208.
16. Piersanti F. La autogestión en salud. En: Basaglia F et al. *La salud de los trabajadores: aportes para una política de la salud.* México (DF): Nueva Imagen; 1988. p.101-104.
17. Santos FAZ, Sousa IMC, Gurgel IGD, Bezerra AFB, Barros NF. Política de prácticas integrativas em Recife: análise da participação dos atores. *Rev Saude Publica.* 2011;45(6):1154-9. DOI:10.1590/S0034-89102011000600018
18. Soberón Acevedo G. La reforma de la salud en México. *Gac Med Mex.* 2001;137(5): 419-43.
19. Strauss A, Corbin J. *Bases para la investigación cualitativa: técnicas y procedimientos para desarrollar la teoría fundamentada.* Medellín: Universidad de Antioquia; 2002.
20. Ruiz Olabuénaga JI. *Metodología de la investigación cualitativa.* Bilbao: Universidad de Deusto; 1999.
21. Wetherell M, Potter J. El análisis del discurso y la identificación de los repertorios interpretativos. En: Gordo López AJ, Linaza JL, editores. *Psicologías, discursos y poder.* Madrid: Visor; 1996. p.66.
22. Zakus D. La participación comunitaria en los programas de atención primaria a la salud en el tercer mundo. *Salud Publica Mex.* 1988;30(2):151-78.
23. Zambon VD, Ogata MN. Configurações dos Conselhos Municipais de Saúde de uma região no Estado de São Paulo. *Rev Esc Enferm USP.* 2011;45(4):890-7. DOI:10.1590/S0080-62342011000400014

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