Governance indicators for the development of bi-national strategies on social protection for the health of immigrants[1]

Indicadores de gobernanza para el desarrollo de estrategias binacionales deprotección social en la salud de los migrantes

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Resumen

Este artículo presenta resultados de un estudio cuyo principal objetivo fue identificar los actores clave, sus roles, coaliciones y los espacios de interacción para el desarrollo de protección social en la salud de los migrantes. Se identificaron 10 categorías de actores clave para estrategias de salud para emigrantes, así como metas de política y estrategias binacionales de salud con diferentes niveles de factibilidad y efectividad. Un seguro público binacional de salud para emigrantes indocumentados es factible pero requiere una gran inversión y movilización de recursos públicos. Para ello se deberán desarrollar nuevas iniciativas dirigidas a resolver los problemas de equidad y acceso en la salud de los migrantes.

Palabras clave: Gobernación; Protección social; Migrantes; México; EE.UU.

Abstract

This article presents results from a study where the main objective was to identify key actors, roles, coalitions and opportunities for the development of social protection in the health of immigrants. We identified coalitions, interactive spaces and 10 categories of key actors for immigrant health strategies. New strategies for bi-national social protection for the health of undocumented immigrants are of high priority. We found that a bi-national public health insurance for undocumented immigrants is feasible, but will require greater investment and resource mobilization than Mexico currently has. An initiative to address the health of immigrants is needed and should include strategies to improve equity and health care access problems facing immigrants.
Keywords: Governance; Social Protection; Immigrants; Mexico; United States.

Introduction

In the field of the reforms regarding the financing and provision of health services for the past 10 years, the democratization of health raised the need for greater access, equity and social participation, causing this to become one of the main policies to develop in Mexico (SSA, 2001, 2009). In fact in the last two national programs, the importance was recognized of all social actors involved in the generation of health actions for the underserved population representing social security to become more involved (SSA, 2009). As part of the process of health democratization, it also added the governance variable understood as the identification of the social actors, processes, interactions and rules that determine the provision of health services (Arredondo et al., 2011).

In this context, the governance analysis and social protection cover healthcare for Mexican immigrants and their families in Mexico and the United States. Taken more validly as one of the themes of the bi national health policies (Cocrhan, 1997). Therefore, the development of government indicators around the demand and the granting of health services for the uninsured population (which includes migrants and their families) is seen as a priority need. The purpose of identifying barriers, opportunities, challenges and feasible scenarios enable the development of social protection programs in health for vulnerable groups (Arredondo et al., 2011).

The issue of vulnerability in social security and healthcare becomes more important because more than half of Mexican immigrants from 18 to 64 years old do not have health insurance neither in Mexico nor in California (California Health Care Foundation, 1999). This context is the reason for the development of a Social Protection System in Health (SPSS). This raises lines of action to ensure greater access to services, depending on the health care needs for Mexican migrants. We have analyzed in this regard situations that suggest barriers of cultural access, geographical and economic services with public and private medical insurance in the places of origin and destination (Bronfman and Díaz Polanco, 2003). Different analyzes about the access to preventive and curative health services

by migrants and their families have shown that the provision of social protection in health is subject of an extensive debate; both in Mexico and the U.S. (Arredondo et al., 2011; Wallace et al., 2008).

The information about the available services show that more than half of Mexican immigrants 18 to 64 years had no health insurance in 2000 (ISMECAL, 2003; Hall and Rivera, 1997). Based on this it has encouraged the creation of bi national health programs and public or private health insurances, but their implementation and deployment scenarios have been poorly documented (Tuirán, 2000; ANM, 1994). There are initiatives oriented to realize events that promote access and improved healthcare among the Mexican people living and working in the U.S. who do not have health insurance, as the Binational Health Week (see: http://hia.berkeley.edu). The program " Go healthy, come back healthy", where the Institute of Mexicans in the Exterior participate, a decentralized entity of the Ministry of Foreign Relations (SSA 2006, 2011, 2012). However, in some studies it has been shown that since the implementation of the TLC, all of these programs face cultural resistance until the political, legal and administrative lend help (Homedes and Ugalde, 2004; Gómez et al., 1997; Frenk et al., 1994).

Also there have been development initiatives to extend the health services offer for this population particularly in the border zone. That is the case of organizations such as Health Net (Health Net, 2003) and the Health Window in all Mexican consulates in several U.S. cities (SSA, 2011). These mechanisms of health services they offer represent for this project a opportunity to characterize governance mechanisms related to the access, especially by illegal immigrants in California. This approach seeks to identify opportunities that promote health governance through social protection and the provision of health services for vulnerable populations in a scenario of high feasibility.

The theme of actions about social protections in healthcare oriented to Mexican migrants has been presented in multiple forums during the reunions of the "Bi national Health Week" (SSA, 2009). It has been used for various purposes in the political agendas of Mexico and the U.S. in favor in one case and subjected to circumstances of political and economic environment on the other. However, more information is needed with new indicators and scenario building of high feasibility to identify agreements and arrangements needed to advance the creation of a social protection system. Bi national health established its scope in the current scenario (Holzman, 2003; Canales, 2002, Cámara de Diputados, 2004).

To measure the problems related to governance, social protection and health of migrants as talked above is considered relevant to establish the map of actors (policy frameworks, processes, interactions, etc) linked to the creation and health promotion services (Orozco, 2008; Boismenu and Alain, 1995). Therefore we spoke about the review of trade agreements on programs, services, health insurance, and an analysis of the legal frameworks that sustain the supply and the access to health services in both countries. Incorporating economic indicators of equity and access to health (Wallace et al., 2008; Arredondo and Najera, 2006). On the other hand it is also very important to identify the social actors involved, and the types of interactions and opportunities for interaction among different social actors in the health system. This information is strategic in so far that it promotes the identification of indicators of governance and its relation to the opportunities and challenges for public policy of greater social protection in health (Arredondo and Orozco, 2008; Hufty, 2006).

In summary, from the study of governance and social protection in the migrant population, the aim of this paper is to present the main results of the key players, their roles, coalitions and interaction spaces for the development of social protection strategies of the migrant health.

Methodology

It was developed a design of an evaluable investigation and qualitative type, based in the documental analysis in-depth interviews and case studies in communities of Guanajuato, Mexico and California, USA. The methodological procedures included three stages:

Step 1: Document analysis of trade agreements and immigration agreements (35 sources of informa-

tion). Interviews with key informants to characterize opportunities and challenges among policy makers, NGO leaders and health service users.

Step 2: Realization of the case studies using ethnographic fieldwork in the communities of origin of migrants in Mexico and the target communities in California. On selecting informants in the U.S. there were established priorities based on the communities to select. Saturation criteria was used to establish a relevant fee in the estimated number of networks and key informants.

Stage 3: Helped by the software ATLAS-Ti and POLICY-MAKER, an integral analysis of results was made to identify the main governance indicators as well as the determinants and conditioning of the feasibility of a bi-national health insurance for migrants. Applying a feasibility logarithm that determined the opportunities and barriers as well as scenarios of political feasibility, financial and technical.

In order to reach the objectives and contrast the empirical expectations using the analytical model of governance in health systems, key actors were questioned in depth interviews. Integrating the results to the development of a study about the social actor, their tasks, interactions and the operation rules in the field of social protection system in healthcare. In the first case it was preceded to a transcript of the interviews and field notes for analysis by using the program ATLAS-Ti. This procedure allowed them to thematically arrange interview issues by using codes created specially for this situation. The second procedure consisted of conducting a political mapping of key actors using the POLICY MAKER program. As part of this exercise there were challenges analyzed and opportunities referred by the informants to the definition of strategies and their degree of feasibility. Also employed applied political analysis techniques.

They were characterized as political actors in the project to individuals, groups and agencies with capacity to influence policy goals with some kind of link with migration phenomenon. The performed analysis was focused on three dimensions: position, power and general characteristics. The position of the actors was derived from the analysis of field interviews regarding to the definition of bi national security schema for undocumented immigrants and their families. The power of actors is defined in terms of their ability to mobilize resources and influence decision-making at various levels. The general characteristics refer to the type of actor and the sector to which it belongs. The assignment of the status of the actors considered two criteria: interest groups and key actors. The difference between the two typologies resided in that the first have less ability to influence the formulation and conduct of public policy.

Results

Governance indicators: characteristics, identification, relationships, interactions and transactions between the social actors involved in the study

The characteristics of the actors are identified in chart 1. In the actor's name are included dependencies, groups and individuals who are assigned an abbreviation, which is useful for the presentation of the artwork and diagrams in this section. The values shown in the columns of position and power are defined automatically by the POLICY MAKER through a logarithm that combines values in function of the commitment of the actor with the policy goals, the offered resources in favor of the goals, the availability to support the goals and the organizational resources that can support the goals and mechanisms of interaction.

Eighteen actors were analyzed, of which 33% had a high support position, 39% medium and 28% support low support, resulting notably not having found actors who have expressed some degree of opposition. The group of actors with a high support position includes actors from government, politics, and NGOs. The medium support of government and policy sectors for its part, the actors in a position of low support for government sector accounts, political, and social sector NGOs.

Chart 2 shows the characteristics of the main identified actors, NGOs, community groups, Representatives of the Legislative Power, Representatives of the Federal Executive Power and the Representatives of the state powers. The results on the status allowed to identify the actors are called NGOs and community groups as interest groups, while the ac-

Chart 1 - Position, power and type of sector of the main political actors

Actor Name	Position	Power	Type / Sector
Congress Health Commission (ComSaDip)	+++	+++	Sub sector of the political unit
Border Health Commission (SRE)	+++	+++	Sub sector of the government unit
Community Foundation	+++	+	Non-governmental organization
Department of Epidemiology (SSG)	+++	+++	Sub sector of the government unit
Department of International Affairs SSA	+++	+	Sub sector of the government unit
Mexican Foreign Service Ambassadors	+++	++	International sector Individuals
Bajio Community Foundation (Guanajuato)	++	++	Non-governmental organization
International Health Servicies (IHSONG)	++	+	Non-governmental organization
Migrants home (Cortazar, Guanajuato)	++	++	Sub sector of the government unit
Office of Immigrant Affairs Guanajuato	++	++	Sub sector of the government unit
Vulnerable Groups Committee of the Congress	++	+++	Sub sector of the political unit
Opinion Research Center of the Congress	++	++	Sub sector of the political unit
Social Security Commission of the Senate	++	+++	Sub sector of the political unit
Agricultural Development Center	+	+	Non-governmental organization
Migrant Health Program (SSG)	+	+	Sub sector of the government unit
A Embroidery Association of El Gusano	+	+	Non-governmental organization
Relatives of migrants (Mineral de la Luz, Gto.)	+	+	Social sector group
Border Affairs Committee of the Senate	+	+++	Sub sector of the political unit

ESCALA: +++ = High; ++ medium; + = low
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

tors classified as Legislative, Executive and Federal State Powers were classified as key players.

Intervention spaces shown for the case of NGOs are associated with social networks with the community level, and with margins of influence with regional scope. The case of community groups was similar although this group of actors can mobilize resources starting from family relationships. In the case of the Legislative Power, it was established that its spaces of intervention are associated with the development of legislation, representation, political negotiation and intermediation of interest groups they represented before the Chambers. In the case of the federal executive power it was that, that established which competes as the intervention space the public sphere and the provision of services. Which is the representation of specialized sectors (health, foreign affairs) and the protection of the social rights. The classified actors under the state powers express similar intervention spaces to the previous actor, although its relationship to these spaces is related more to providing services and the implementation and conduct of social welfare policies.

With respect to the modes of expression, the NGOs show more proactive patterns, while the community groups reported more passive and cyclical patterns. The key actors present a little more dynamic facet, showing that the actors of the Legislative Power express regulatory cutting patterns when connected to the formulation and enactment of laws and regulatory frameworks by the observed dynamics in the Chamber of Deputies and Senators. It was established that the mode of expression of these actors is dynamic, while the theme of the development of social protection strategies in health with a bi national character, was proposed by legislators from both chambers a conjectural, to which it was established that some committees may have a more pro-active character, starting from social evidences that encourage its mobilization.

The actors that were presented in the study to the Federal Executive Power showed equally normative modes of expression, in the sense that their actions attend public mandates of different kinds.

Chart 2 - Characteristics of the actors in the field of health

Characteristics of the actors	Actor I	Actor II	Actor III	Actor IV	Actor V
Type	NGOs	Community groups	Legislative power (Deputies and Senators)	Federal Executive Branch (SSA, SRE)	State Powers (SSG, SEDESOL, Town Hall)
Status	Interest Group / Formal	Interest Group / Formal	Strategic Actor / Formal	Strategic Actor / Formal	Strategic Actor / Formal
Intervening space	- Social Network - Community - Regional	- Social network - Kinfolk - Community	- Formulation of laws - Political Representation - Political negotiation - Intermediation	- Public - Provision of services - Social representation - Protection of social rights	- Public - Provision of services - Protection of social rights
Mode of expression (response type)	- Pro active	- Passive - Coyuntural	- Normative - Dynamic - Coyuntural - Pro active	- Normative - Dynamic - Coyuntural - Pro active - Prescriptive	- Normative - Dynamic - Coyuntural - Pro active - Prescriptive
Declared interests	- Facilitate regional development - Support the local economy -Commitment to service - Declared interest	- Receive Medical Attention - Demand for social protection - Social support	- Defending the rights of represented and interest groups - Develop laws - Partisan agenda	- Safeguarding the right to health - Identify needs and prioritize actions - Coordinate social response	- Safeguarding the right to health - Identify needs and prioritize actions - Coordinate social response
Ideology, vision	- Collectivist - Egalitarian	- Collectivist - Egalitarian	- Collectivist - Egalitarian - Sectarian (left, center, right)	- Collectivist OSC - Inclusive	- Collectivist - Sectarian (left, center, right) - Inclusive
Controlled resources	- Culture - Social Capital - Communal	- Culture - Social Capital - Communal	- Political Capital - Culture - Capital - Normative framework	- Public Organizations - Culture - Capital - Normative framework	- Public Organizations - Culture - Capital - Collective - Communal
Perceived importance	Medium	Low	High	High	High

Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

The response of these actors is dynamic, but can be conjectural to demands that affect the public interest to which they show a prescriptive response. In the case of the executive power actors at a state and municipal level, the modes of expression are similar to the previous actor. However, it is important to consider that it corresponds to local levels the instrumentation and administration of government programs, adjusting their actions to prescriptive frameworks that define the nature of the actions to develop and the specific procedures to develop them.

Regarding the declared interest, represented of the NGOs representatives expressed their commitment to impact in the regional development and economy of the communities in which they carry out their activities, in the case of these actors, expressed the importance of dedication to service. Community groups expressed the importance of having access to health services, in a context where organizational changes were observed and regionalization of health services. For these stakeholders, the social health protection becomes more relevant in a context of migration because the family faces different risks and health problems, as well as a differentiated access to health care, in situations like this, these actors expressed the importance of support by deploying specific support strategies.

The actors of the Legislative Power expressed the importance of their work in defending the rights of their constituents, and the formulation of laws, taking care of the agendas and interests of the political parties to which they belong. The Federal Executive Power actors expressed their interest in safeguarding the right to healthcare as well as to document needs for prioritization of actions within a framework where coordination of the social response was considered relevant. Regarding the declared interests of the actors of the state powers, they correspond to the federal executive, taking greater care orientation of the local demands within a framework of priorities demand attention and links with local agents to enhance the capacity of response. With regard to the ideological positions of the actors NGOs expressed collective and egalitarian positions, expressing the importance of attending citizens living in conditions of economic and social vulnerability. Community groups also expressed collectivist values although their position had individualistic traits when looking at answers to demands of themselves or from family members. The actors of the Legislative power expressed values equally collective and egalitarian values, although they guided them from ideological positions represented by their political parties in the legislature (left, center, right). The Federal Executive informants expressed collectivist and inclusive attitudes, but in an efficient framework directed at focusing actions. While state power actors expressed similar values, although oriented from positions somewhat sectarian.

The same chart 2, shows that the controlled resources by the groups of interest, NGOs and community groups related to cultural and social capital expressed solidarity and collaborative responses. Additionally, the actors of NGOs and community groups expressed degrees of control over common resources. In the case of the actors of the legislative branch they have the political control over the political capital. Displaying cultural practices of interaction with their peers and their constituents. These actors also control capital resources and regulatory frameworks to formulate and promulgate. The actors of the Federal Executive Power showed control over public organizations in charge of attending the necessities of the citizens for which they expressed to count also with cultural practices of access, social capital that supports the nature and quality of their responses. As well as the policy frameworks that transfer to state and national executing agencies. In the case of state powers, the controlled resources were similar, although the actors were located more in the area of implementation and management policy.

Regarding the perceived importance, it is clear to note that interest groups had a low (community groups), average (NGOs) while groups classified as key actors had a high importance. The support of this argument is illustrated in chart 2, which shows that the key players have more formality in their organization have higher declared interest. Above all, control strategic resources for the development of strategies for social protection in health as a matter bi national. A reflection issue of great importance in this context would be that the interest groups, particularly community groups are facing more directly the lack of health protection schemes and

the consequences of it. However, this sector is both the least capacity to mobilize support and engage the resources of key actors according to their needs.

To approach the results on type and size of transactions in the context of the health system there were established as central transaction negotiation. The management, distribution and reciprocity, for considering them key in the involvement of stakeholders and the driving social welfare policies (see Chart 3). The overall balance of the transactions between the actors of the health system was analyzed from the capacity of finance functions, rectory and service delivery. In these cases, the transactions with higher weigh were negotiation, address and reciprocity, with an index of medium capacity, except the item corresponding to distribution.

In the same chart 3, it is observed that the function of the rectory and regulation had a more heterogeneous behavior. The negotiation and reciprocity transactions reported the lowest capabilities, which demonstrate the lack of capacity in respect to the participation reported in the literature for the Mexican case. In contrast, the transaction management had a high capacity which is reflected in the promulgation of many legal frameworks in this decade to promote the health protection right of the Mexicans. The distribution transaction shows a medium capacity, whenever health policy in Mexico has been proposed to correct the health care gaps of the population that has no access to public safety schemes.

Another analyzed aspect as part of this mapping led to the development of actors coalitions for promoting strategies referring to the density of relations between actors, which is described in Chart 4. It can be observed that this density tends to be less around the relationship between interest groups and stakeholders observing that it tends to be lower in community groups. In contrast, the NGOs seem to have a greater involvement not only with the other group of interest, but also with other key stakeholders particularly with the state power.

The results in Chart 4, suggest that the key players are more linked, which has enabled the recent changes to the legal and regulatory frameworks that tend to strengthen social protection of health in Mexico designed for people without social insurance. Under this principle, national debates had been created on public insurance portability. Thus will strengthen the response capacity of Border States for an eventual repatriation of undocumented migrants living with any health needs to prevent them from moving to their places of origin. This table additionally shows that the actors of the state powers have a lower density than the Legislative and Executive Branch, while these actors have a higher density with the federal government.

In the chart 5, the results suggest that for the described transactions the biggest capacities are located on the first level of attention, where the highest value is placed on reciprocity. When users of this level receive more compensation than the rest of the levels of attention. At the same time, it is in the first level where medium values are presented for distribution and negotiation, but it shows the lowest value in the direction.

It is also suggested that the transactions of the interest groups with the key stakeholders are more limited to the second and third level of attention (see chart 5). In the case of the second level, it is seen that the highest value is for the direction and the lowest for the rest of the transactions with a low capacity. On the third level there are the most limited transactions, highlighting the highest capacity in direction and the lowest in reciprocity. On this level there where no identified capacities in relation to the negotiation and distribution.

The results in the chart 6, shows that the biggest transformation capacity is observed in the public sector, which constitutes one of the most relevant axes of the governance analysis; because the social health protection involves the public security offer directed to populations at risk, poverty and impoverishment in respect of private health expenditure. In this sector it is seen that the highest capacity is reported for distribution, reflecting government efforts to correct equity gaps in the Mexican health system.

This values contrast with the observed capacities to the private sector, where they identified direction and distribution linkages, being the first one the highest and the second one the lowest. The public and private relation shows a more favored stage, which could be attributed to the powers conferred by

Chart 3 - Type and size of transactions between actors by health system functions

Type of Transaction	System Functions		
	Finance and Insurance	Rectory and Regulation	Provision of services
Negotiation	+ +	+	+ +
Direction	+ +	+ + +	+ +
Distribution	+	+ +	+
Reciprocity	+ +	+	+ +

Low Capacity +
Medium Capacity + +
High Capacity + + +
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

Chart 4 - Gradient density relations between actors

Relations between actors / density relationships	Actor I (NGOs)	Actor II (Community groups)	Actor III (Legislative power - Deputies and Senators -)	Actor IV (Federal executive branch, -SSA, SRE-)	Actor V (State- Powers SSA, SEDESOL, Town Hall-)
Actor I	+ + +	+ +	+	+	+ +
Actor II	+ +	+ +		+	+
Actor III	+		+ + +	+ + +	+
Actor IV	+	+	+ + +	+ + +	+ +
Actor V	+ +	+	+	+ +	+ + +

Low Capacity +
Medium Capacity + +
High Capacity + + +
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

the 2003 reform to the General Health Law to encourage expansion of coverage processes and reducing barriers to access to the health services. In this case, distribution presents the highest value (medium) and the remaining transactions, a low capacity.

The chart 7 shows that the transactions between actors by geographical areas present the highest values for the national level, particularly in the negotiation, direction, and media for the distribution and reciprocity. This fact is important because it complements those reported at the beginning of this section, in the sense that they are the key actors who have higher binding capacities and control of significant resources. It is seen that the capabilities tend to decrease as the level is more disaggregated geopolitical and operational. Intermediate levels like the regional and the state report medium capacities for negotiating transactions and direction. At these levels there is a slight variation for the distribution and reciprocity cases

In the chart 8, we identified the relations between actors starting from nodes of relationship and interaction. In this case, the actors that are classified as interest groups (NGOs and community groups) show lower transactions and relative weights in their entailment with the key actors (Legislative Power, Executive and Federal Power, and state powers). In this context, the transactions of the actors I and II have a strong content of distribution and reciprocity. At the same time, the NGOs are the ones that reflected higher transactions with other actors compared to the situation of community groups.

A big part of the transactions of the key actors tend to focus in the Executive Federal Power. This characterization suggests that this actor is very important for maintaining direct or indirect transactions with all the actors in the analysis. At the same time it could be argued that the centralist tradition of Mexico influences the centrality of the Actor IV. When interacting directly or indirectly with all the

Chart 5 - Transactions between players by level of attention in the health system

Type of Transaction	Levels of care		
	Primary	Secondary	Tertiary
Negotiation	+ +	+	–
Direction	+	+ +	+ + +
Distribution	+ +	+	–
Reciprocity	+ + +	+	+

Low Capacity +
Medium Capacity + +
High Capacity + + +
Null Capacity —
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

Chart 6 - Type and size of transactions by level of attention between actors per sector of the health system

Type of Transaction	Relationship Public / Private		
	Relationship Public / Private	Relationship Public / Private	Public Relationship / Private
Negotiation	+ +		+
Direction	+ +	+ + +	+
Distribution	+ + +	+	+ +
Reciprocity	+ +		+

Low Capacity +
Medium Capacity + +
High Capacity + + +
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

Chart 7 - Type and size of transactions between actors by geopolitical area

Type of Transaction	Territorial structures			
	Municipal	State	Regional	National
Negotiation	+	+ +	+ +	+ + +
Direction	+	+ +	+ +	+ + +
Distribution	+ +	+ +	+	+ +
Reciprocity	+	+	+ +	+ +

Low Capacity +
Medium Capacity + +
High Capacity + + +
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

Chart 8 - Type of relations between actors and articulation of key nodes of interaction

Transactions between actors	Actor I (NGOs)	Actor II (Community groups)	Actor III (Legislative power-Deputies and Senators -)	Actor IV (Federal executive branch -SSA, SRE-)	Actor V (State Powers-SSA, SEDESOL, Town Hall)
Actor I	Reciprocity (35%)	Distribution (25%)	Distribution (10%)	Distribution (5%)	Distribution (20%) Reciprocity (5%)
Actor II	Distribution (30%)	Reciprocity (30%)	Distribution (5%)	Direction (5%) Negotiation (10%) Distribution (10%)	Reciprocity (10%)
Actor III	Distribution (10%)	Direction (25%) Distribution (15%)	Reciprocity (25%)	Negotiation (15%)	Reciprocity (10%)
Actor IV	Reciprocity (5%) Distribution (5%)	Direction (5%) Negotiation (5%)	Negotiation (20%)	Negotiation (10%) Direction (10%) Distribution (10%) Reciprocity (10%)	Reciprocity (10%) Negotiation (10%)
Actor V	Reciprocity (30%)	Distribution (20%)	Reciprocity (10%)	Negotiation (20%)	Negotiation (20%)

Note: Percentages indicate the relative weight of the transaction.
Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

actors in the system. This table also reflects that community groups are the ones that report a lowest relation between the nodes and transactions than the rest of the actors.

It is important to highlight that the principal nodes of interaction between actors are presented in the interaction between the state executive power and the community groups, followed in order of importance by the executive federal power with legislators and finally NGOs with community groups. This is highly relevant because it is from the interaction of these actors that coalitions between actors between actors are created and different positions of each actor regarding the need to develop social protection strategies for migrants.

The results in the chart 9, allow to support the presented arguments for the described situation in the previous figure. Indeed, chart 9 shows that the interest groups (NGOs and community groups) are more locally linked every time that the actions of the interviewed NGOs are directed to improve the socio economical situation of the communitarian actors. However, the community groups are presented as receptacles for the actions of both NGOs and the rest of the key actors. In this case, it is equally significant the linking of community groups with state powers, particularly for the implementation and direction of community development initiatives and government projects.

These results suggest that the key actors have the highest nodes in interaction spaces primarily directed towards attending the situation of the actors classified as community groups. In this regard, the most relevant nodes relate to community development initiatives and government projects. Additionally, the Legislative Power shows how nodes specific of their nature of creating laws and the promulgation of regulatory frameworks aimed at expanding the accessibility to the health services for community groups. This actor concentrates on the largest political capital.

In the case of the Federal Executive Power, some of the more relevant nodes start from the negotiation processes with the actors of the legislative power regarding the formulation of policy frameworks and budget allocation. In this case, the actor is equally relevant for its articulation with state powers, which are seen as implementers, federal initiatives managers and their own.

As a conclusion, this section shows that the interest groups had less control and showed a reduced ability of proposal and negotiation for the creation of social health protection strategies with bi national characteristics. However, the analyzed key actors

Chart 9 - Identification of nodes from the spaces for interaction among actors

Actors / Nodes	Actor I (NGOs)	Actor II (Community groups)	Actor III (Legislative power- Deputies and Senators -)	Actor IV (Federal executive branch -SSA, SRE-)	Actor V (State Powers-SSA, SEDESOL, Town Hall)
Actor I	- Community Networks - Community Development Initiatives - Government Projects	- Demand for Health Services - Community development initiatives - Government Projects	- Formulation of laws - Community development initiatives -Government Projects	- Community development initiatives - Government Projects	- Community development initiatives - Government Projects
Actor II	- Demand for health services - Community development initiatives - Government Projects	- Demand for Health Services - Community development initiatives - Government Projects - Community Support Networks	- Formulation of laws - Community development initiatives - Government Projects - Access Rules	- Demand for health services - Provision of health services - Distribution of health services - Access Rules	- Demand for health services - Services offer - Distribution of resources at the community level - Special Needs Attention - Community development initiatives - Government Projects
Actor III	- Formulation of laws - Community development initiatives - Government Projects	- Formulation of laws - Community development initiatives - Government Projects - Access Rules	- Network of relationships and political agreements - Negotiation processes for the formulation of laws - Establishment of consensus	- Network of relationships and political agreements - Negotiation processes for social policy - Consensus and application frameworks - Negotiation of funding	- Implementation of political agreements - Implementation of social policies - Application of normative frameworks - Negotiation of financing
Actor IV	- Community development initiatives - Government Projects	- Health services demand - Health services provision - Health services distribution - Access Rules	- Network of relationships and political agreements - Negotiation processes for social policy - Consensus and application of normative frameworks - Negotiation of financing	- Network of relationships and political agreements - Negotiation processes for the implementation of social policies - Consensus and application of normative frameworks - Negotiation of financing - Inter-governmental Network	- Implementation of political agreements - Transfer of social policies -Transfer of normative frameworks - Negotiation of financing - Network of relationships and political organizations and NGOs
Actor V	- Community development initiatives - Government Projects	- Demand for health services - Offer of services - Distribution of resources at the community level - Special Needs Attention - Community development initiatives - Government Projects	- Implementation of political agreements - Implementation of social policies - Application of normative frameworks - Negotiation of financing	- Implementation of political agreements - Transfer of social policies - Transfer of of normative frameworks - Negotiation of financing -Network of relationships and political organizations and CSOs	- Network of relationships and political agreements - Processes of social policy implementation - Application of normative frameworks - Negotiation of financing - Inter-governmental Network - Special Needs Attention - Community development initiatives - Government Projects

Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

have an important linkage and guidance to address the situation of community groups. Particularly by supporting the state powers.

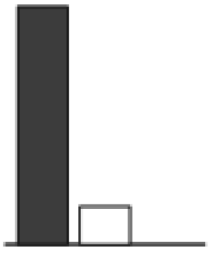
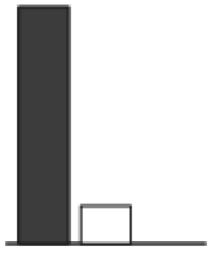
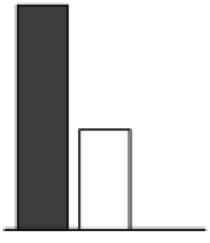
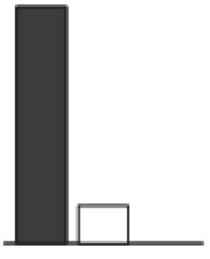
It is important to establish that the scope of governance of these matrices suggested the need for greater empowerment and development capacity by the interest groups, especially community groups. Governmental actors show some important advances from the reforms that have recently boosted in the Mexican government. As an example of it, it is enough to emphasize new programs and strategies with broad social participation of users and interest groups, such as the health receptions in the Consulates, Popular Health Insurance, Meetings with health authorities and leaders of social networks of family support migrants, Return Healthy Go Healthy program and among others. The greatest reaches of these reforms are of national and or state territorial nature, pointing to the need to strengthen national capacities for social protection in health. Since these initiatives do not have a extraterritorial reach, it should be defined strategies for further deployment and strengthening bi national outreach strategies grounded in national capacity building, in case the demand for Mexican nationals were treated in Mexico.

Position of the actors regarding goals, mechanisms and coalitions in Mexico

Once the goals and actors are presented, the political mapping allows a weighting of the position of the actors for each goal and mechanism presented in chart 10. This exercise initially allows the opportunity to identify the variability of the support and is the process prior to the analysis of opportunities and barriers reported by respondents in interviews.

The analysis of the position of actors regarding goals and mechanisms search to anticipate the challenges related with the feasibility of a bi-national health secure for non documented immigrants, from the perspective of the interviewed actors. This position represents the addition of the placement of all the actors regarding the goals and mechanisms. The chart 10 presents the average of the support derived from the position of players regarding targets and mechanisms.

Chart 10 - Feasibility of targets and mechanisms from the proposed goals policies

Political Goals	Feasibility of the target	Mechanisms of policy	Feasibility of the mechanism
Increase the accessibility to health services to the immigrants in their home tows and their destiny, Identifying opportunities in the socio political environment for the offer and the utilization of those services		Creation of a bi national insurance for undocumented immigrants	
Characterize the problematic of governance and social health protection to define scenarios directed to the implementation of health services of bi national character for undocumented emigrants in the USA		Linkage of the actors and development of governmental capacities in Mexico	

Support Without position Opposition

Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

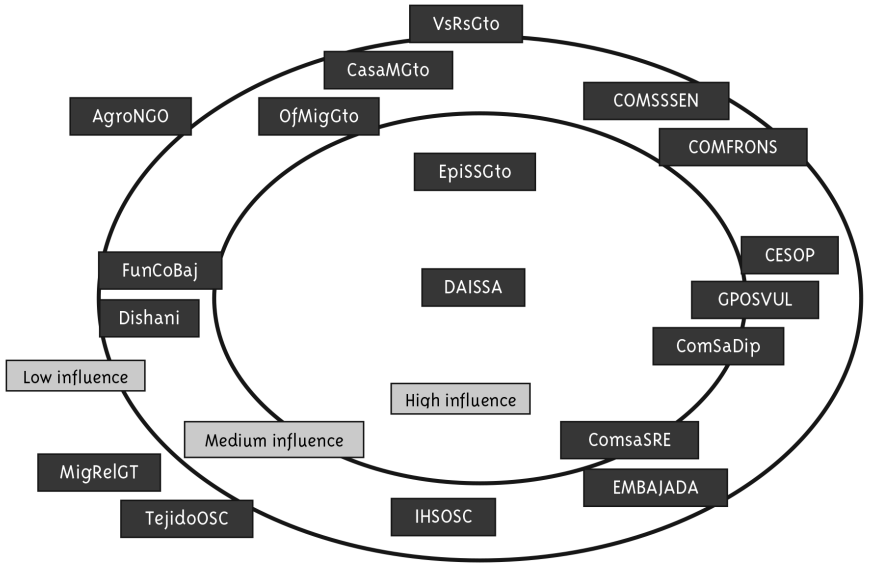
Even we have not found positions against it, there is a high proportion of mobilization towards the goal of establishing the problems of government rules to define favorable scenarios for a bi national health insurance. This tendency agrees with the data where we found skeptic positions of political and government actors as well as not knowing the legal frameworks to fundament the creation of a bi national health insurance. On the other hand, these same actors presented situations that are challenges for this initiative. Such as the legal barriers of accessibility to public services for undocumented immigrants and the fear of this population of using health services in the USA. Regarding the mechanism of this goal its feasibility was higher, because of the lack of interest of linking with other actors and associations that helped the development of government capacities for the creation of a bi national health insurance.

Regarding the goal of expanding the accessibility of health services for undocumented immigrants, we obtained most feasible evidence derived from a position of greater support from those interviewed. This situation is very similar to the pattern established for the mechanism. Having found few references to question the creation of a bi national health insurance. In the field, these positions were recorded with community actors who were going through a conflict with health authorities for the withdrawal of medical support in their locality.

Discussion and conclusions

The analysis of the interviews and political mapping show that the SSA is in a federal level, the actor with greater support and ability to influence the proposed bi national strategies on health and to develop skills that promote access to health services of undocumented migrants in the U.S. As well as schemes of social health protection for their dependents who remain in their home communities. It was in the SSA where it was collected information regarding experiences and security options for the target population (see Figure 1).

Figure 1 - Actors Coalitions and their influence on levels of social protection policies in health



Source: Arredondo A, et al, Gobernación y Protección Social en la Salud de los Migrantes. Informe Técnico , INSP, Cuernavaca Mex. 2010.

With lower capabilities they placed actors in the government sector in the state levels state and federal, political actors and NGOs. Despite its location on the map each of these players expressed varying degrees of willingness to participate in an experience related to bi national health security. Such is the case of the actors involved in the Foreign Service, which offered support to promote more feasible options through U.S. consular services.

In this position there was one NGO located whose representation is linked to the external service and altruistic sectors in the U.S. Meanwhile, political sector actors referred great interest in the study problematic, providing the creation of spaces within legislative bodies to promote the creation of legal frameworks to protect the health of Mexican migrants abroad. Finally, government sector actors Guanajuato presented with significant potential to favorably influence in policy goals. In this sense, they were referred initiatives of the program "3 x 1" (This program is the response of the Federal Government of Mexico to the migrants in order to realize community projects, adding the financial participation of the three branches of government with clubs and federations of migrants), and the creation of state institutions where they offered a space for participation called Entrepreneurs Emigrants Council of Guanajuato.

The NGOs got a more differentiated potential. In a first group there were identified those linked to community development projects. In two of these cases there was a indirect link with health projects, but instead there was offered support to access groups and communities with whom these organizations have productive projects and community development. However, one case was found that by their competence did not express interest to support the initiative of study.

The different indicators of governance allowed strengthening the feasibility of new strategies for the advancement of social protection in health of migrants. Among the major political actors involved comparing social actors versus federal, state and level. The Federal level was the best positioned and most powerful. Indeed, members of the legislative committees of deputies and senators as well as executives of the Ministry of Health and Ministry of Foreign Affairs. Social actors were better positioned and more power for the health of migrants. Continued calling attention even when they worked with family networks and services at the state level, the state level players had less power. But even caught the attention of the low positioning and the power of NGOs or community networks for migrants at a state level. The positive part is that there already exists, there social actors and programs or activities should be developed to promote the creation of more concrete actions of social protection of the migrants and their families.

About the characteristics of the social actors involved, the first aspect that stands out is the passive role and cyclical of the community groups. Surely this is closely related to the absence of a culture of active social participation in the Mexican social context in general and in these types of groups in particular. About the NGOs, it is important to highlight their proactive role as facilitators in the regional development. Although they are not yet the best positioned players in terms of social protection in the health of migrants. The governmental actor of the legislative and executive power is demonstrated as a very dynamic role they played in the development of the legal framework and the actions addressed to the advance of the social protection of migrants. Obviously, these are the social actors who control all the resources and greater opportunities for intervention both at the federal level, state, regional and international.

This last part is vital, because the actors that represent the federal government are the only ones that participate directly in the international level spaces. Spaces of high relevance in the development of social policies and programs aimed at migrants. About the spaces of intervention and action by NGOs and community groups, it is important to highlight the links that these actors establish at Community level of family networks of migrants with high influence margins and in some recent cases on both sides of the border, especially when kinship networks exist between people of California and Guanajuato.

In the United States, migration and international relations are the exclusive responsibility of the federal level. Being that bi national health issues are complicated by the government system , which

gives each state the responsibility for regulation and medical supervision. The federal government participates in the financing of certain health insurance programs for specific populations, including Medicare for seniors and Medicaid for lower income families. The approvals of private insurance plans are the responsibility of each State. As a result, bi national private health insurance plans in California such as Health with Health Net, are not available for purchase outside of California. Texas lawmakers have rejected legislation that would allow the state to create similar plans. This division of responsibilities for migration and health care among federal and state governments in the U.S. make the development of a bi national health insurance more complicated, whether in public or private funding. As a result, efforts that focus on a single state such as California are more likely to be successful at first.

About the control of resources and the ideology of each actor, there are extremely relevant elements to identify potential conflict points and enhance synergy in resource management itself. For example, there are scenarios where community networks, NGOs and actors of the legislative or executive powers present an ideological conflict or political party conflict. Generating more points of disagreement and conflict of collaboration where the lack of synergy promotes very little a coalition of actors to support policies. Governance levels can be very low.

In regard with the transactions between the involved actors, it is necessary to emphasize the importance of the findings of this study. The main findings being in the financing, governance and regulation of new social protection strategies from the public health system with a high level of demand in the primary care level. The same interactions also left evidence on the private sector commitment to the principles of reciprocity, distribution and trading to develop new strategies for social protection in the health of migrants. The private sector has a clear perception of the high ability in directing resources to health services under their own leadership principles of inputs. Depending on the performance that will leave the health care consumption by family members of migrants.

Transactions between actors favor a promotion of the public-private mix. Especially from prepaid systems under schemes of utilities and financial responsibility between user and provider of health services. Regarding the transactions on the geopolitical area, the most interesting of the study is that it can identify the scope of each actor. From this indicator there could be developed activities and responsibilities by the type of actor from their level and local influence, state, regional, national and international.

Regarding the type of relationship between actors and identification nodes, the most relevant of this indicator is to establish the type of relationship of an actor with others with whom they interact and how they build synergy and collaboration spaces or conflict spaces. Also blocking in the development of joint actions that promote health social protection of migrants. The nodes or spaces of interaction that allow synergy and collaboration can be disaggregated to identify whether the collaboration can have greater impact on reciprocity, distribution, trading or resources to address health actions. Finally, it is important to emphasize the fact of high levels of distribution, reciprocity and negotiating executive actors at the federal level. The identification nodes are very important because the type of interaction that is present in such spaces is what determines the type of activities are present and identifying the most feasible scenarios in the advancement of social protection policy in health migrants.

Referencias

ANM-ACADEMIA NACIONAL DE MEDICINA . El tratado de libre comercio y los servicios médicos, ANM - Comisión Mexicana de Investigación en Salud, México, México DF, 1994.

ARREDONDO, A. et al. *Temas selectos en sistemas de salud*: costos, financiamiento, equidad y gobernanza. Conceptos, Tendencias y Evidencias. Univ. Aut. de Yucatán: Mérida, 2011.

ARREDONDO, A.; NAJERA, P. Équite et accessibilité de la santé au Mexique : évaluation économique du processus de recherche et d'obtention de services. *Santé et Systemique*, Lyon, v. 9, n. 3, p. 71-86, 2006

ARREDONDO, A.; OROZCO, E. Governance and equity from health care reform in Mexico. *International Journal of Health Planning and Management*, Keele, v. 23, n. 1, p. 37-49, 2008.

BOISMENU, G.; ALAIN, N. La restructuration de la protection sociale en Amérique du Nord et en Europe, *Cahiers de Recherche Sociologique*, Paris, v. 6, n. 24, p. 38-51, 1995.

BRONFMAN, M.; DÍAZ POLANCO, J. La cooperación técnica internacional y las políticas de salud. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 8, n. 1, p. 227-241, 2003.

CANALES, A. Migración y trabajo en la era de la globalización: el caso de la migración México-Estados Unidos en la década de 1990. *Papeles de Migración*, Tijuana, n. 33, 2002.

CÁMARA DE DIPUTADOS. MÉXICO. *El impacto de las remesas familiares en México y su uso productivo, Centro de Estudios Sociales y de Opinión Pública*, (LIX Legislatura), México, 2004.

COCHRAN, N. Binational collaboration in health and medical research between the United States and Mexico. In: WARNER, D. C. *NAFTA and trade in medical services between the U.S. and Mexico.* Austin: University of Texas, 1997.

CALIFORNIA HEALTH CARE FOUNDATION (CHCF). *Cross border health insurance.* An overview, CHCF – Healthcare Redesign International, Los Angeles, USA. 1999.

FRENK, J. et al. Consequences of the North American Free Trade Agreement for Health Services: a perspective from Mexico. *American Journal of Public Health*, Washington, DC, v. 84, n. 10, p. 738-741, 1994.

GÓMEZ, O.; FRENK, J.; CRUZ, C. Commerce in health services in North America within the context of the North American Free Trade Agreement. *Revista Panamericana de Salud Pública*, Washington, DC, v. 1, n. 6, p. 327-333, 1997.

HALL, R.; RIVERA, L. Trade in health care products between the United States and Mexico. In: WARNER, D. C. *NAFTA and trade in medical services between the U.S. and Mexico.* Austin: University of Texas, 1997.

HEALTH NET. *Guía de ventajas y beneficios de su plan de salud*, Los Angeles, California, 2003 (Tríptico).

HOLZMAN, J. Manejo social del riesgo: un nuevo marco conceptual para la protección social y más allá. *Revista de la Facultad Nacional de Salud Pública*, Bogotá, v. 21, n. 1, p. 73-106, 2003.

HOMEDES, N.; UGALDE, A. The North American free trade agreement and public health at the US-Mexico border. *American Journal of Public Health*, Washington, DC, v. 93, n. 7, p. 2016-2022, 2003.

HUFTY, M. Gobernanza en salud: un aporte conceptual y analítico para la investigación. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 22, p. S35-S45, 2006. Suplemento.

ISMECAL - INICIATIVA DE SALUD MÉXICO CALIFORNIA. *Historias de ir y venir y la salud mental: manual para promoción de la salud*, Iniciativa de Salud México California, Berkeley, USA, 2003.

OROZCO, E. et al. Estrategias y mecanismos de extensión de cobertura en salud y seguridad social en Paraguay. *Revista Segurdidad e Higiene*, Asunción, v. 42, n. 3, p. 12-14, 2008.

SSA-SECRETARÍA DE SALUD. *La democratización de la salud en México.* Programa Nacional de Salud 2001-2006, México, DF, 2001.

SSA-SECRETARÍA DE SALUD. *Programa Vete Sano Regresa Sano.* Servicios Estatales de Salud. Gobierno del estado de Guanajuato, Guanajuato, 2006.

SSA-SECRETARÍA DE SALUD. *Programa Nacional de Salud 2007-2012*, México, DF, 2011.

SSA-SECRETARÍA DE SALUD, Gobierno del Estado de Nuevo México, EUA. Foro Binacional de Políticas Públicas en Migración y Salud. Programa de Trabajo, 9na Semana Binacional de Salud. Santa Fé, Nuevo México, 2009.

SSA-SECRETARÍA DE SALUD. *Programa de Reforma del Sector Salud 2001-2006, 2007-2012*, Poder Ejecutivo Federal, México, Distrito Federal, 2012.

TUIRÁN, R. Migración México – Estados Unidos. *Hacia una nueva agenda bilateral*, Documento Técnico del Consejo Nacional de Población, México, Distrito Federal, 2000.

WALLACE, S.; GUTIÉRREZ, V.; CASTAÑEDA, X. Access to preventive services for adults of Mexican origin. *Journal of Immigrant and Minority Health*, New York, v. 10, n. 4, p. 363-371, 2008.

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