CONVERGENCIA
Revista de Ciencias Sociales

Healthcare reform: between the biomedical model and health's social character; attention to non-insulin-dependent diabetic patients

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Abstract: Changes in the organization of the health systems recently observed in the world have had a particular impact on the way attention is offered to patients who use the first-level services, provided by institutions in charge of the open population, such as it is the case of Institute of Health of the State of Mexico. Hence, the present work intends to carry out a first description and analysis of the transformation of the health services, before a biomedical attention model facing serious difficulties to respond to the population's needs; in the case we are focused on, the attention to non-insulin-dependent diabetic patients. All of this in the framework of the rhetoric of change that tried to justify a reform in the health services, altogether with the expectations generated by the decentralization process of a key sector for any society's development.
Key words: Public Health, Primary Health Care, diabetes mellitus type 2, Health Care Reform, Qualitative Research, Heath Services
Resumen: Los cambios que en la organización de los sistemas de salud se han venido registrando en el mundo, han tenido un particular impacto en la manera en que se ofrece la atención a pacientes que recurren a los servicios del primer nivel, proporcionados por instituciones encargadas de prestar atención a población abierta, como lo es el caso del Instituto de Salud del Estado de México. Así, el presente documento se propone llevar a cabo una primera descripción y análisis de la transformación de los servicios de salud, de cara a un modelo de atención biomédica que enfrenta graves dificultades para responder a las necesidades de la población; en el caso que nos ocupa, en lo que corresponde a la atención de pacientes diabéticos no insulino dependientes. Todo ello en el marco de la retórica de cambio que pretendió justificar una reforma en el ámbito de la salud, a juego con las expectativas generadas por el proceso de descentralización de un sector que es clave para el desarrollo de cualquier sociedad.
Palabras clave: Salud Pública, Atención Primaria, diabetes mellitus tipo 2, Reforma en Atención de la Salud, Investigación Cualitativa, Servicios de Salud.

Introduction[1]

In Mexico, and perhaps by extension in Latin America, it has become common that when approaching the issue of the reform in health services, the emphasis is made upon the consideration of the macroeconomic, political and social aspects, putting aside the study and analysis of very particular processes which are also central part of said change in the health services' sphere; however, before the absence of its problem-becoming both at institution level and in the academic field have generated a large void in respect to its importance consideration to track the achievements and problems that appear in the reform's framework.

Undoubtedly, one of the disregarded aspects has to do with the manner in which at level attention usually paid to patients, it is possible to achieve a service in accordance with the institutional goals which aim to provide a greater emphasis to policies proper to the public health environment, as an effort that foresees and promotes conditions which protect population's health before the attack of diseases and their possible complications, such as the case of a disease with the characteristics of diabetes mellitus type 2 (non-insulin dependent), an ailment that in recent years has increased its incidence both at worldwide level and in Mexico and Latin America.

According to World Diabetes Foundation, in the early XXI century, diabetes mellitus type 2 already represents between 85 and 95 percent of the cases of diabetes in developed countries, and it is nowadays one of the non-contagious diseases with the most incidence in the world. The age group between 40 and 59 years of age still concentrates the largest number of diabetic people, likewise, it is said that "by 2025, due to the aging of the

[1] The present work is part of the research project: "Social and cultural contextuality and of the family of the diabetic patient as a way of intervention and prevention of diabetes"; which, as from March 2005, is developed in the Center of Research of the Faculty of Political Sciences and Public Administration of the Autonomous University of the State of Mexico (UAEM). Along the first phase, the research had the approval and economic support from UAEM. Whereas the second part, is supported in order to display and publish the final results by the Center of Studies on Marginalization and Poverty of the Government of the State of Mexico (CEMAPEM).

world's population, there will be 146 million people with diabetes aged between 40 and 59 years of age and 147 million of 60 years and older" (World Diabetes Foundation, 2003: 7).

In Latin America, diabetes is also one of the main health problems in the region; it is estimated that 19 million are the people who suffer from this disease, and it is presumed that the number could grow to 40 million in 2025, so it is important to begin introducing preventive measures to prevent and control the presence of this disease in our societies (OPS, 2001).

Positioning

Large part of the decisions that as from the 1970's transform the operation of health systems in the occidental world are affected by a series of "innovative" administrative practices that promise both improving the quality of attention and, in the framework of an increasingly questioned and under heavy economic pressure State's participation, reaching the objective of a broader coverage before the demand of health services. However, there is another background that is important to distinguish, and it is marked by the idea from which the sort of institutional policies and actions are established and projected in this important area of knowledge and of social relation. We witness the prevalence of a model of sanitary attention that responds to clinical and biologic interpretations of the phenomenon and problem of health, the so-called "biomedical model" from where the governmental instances have been working, defining practices and strategies of action centered on the human body's dysfunctions, either at the level of the individual's body attention, or in terms of an idea of collectivity based on the addition of diseased bodies (Granda, 2000; Mckeown, 1986; Pera, undated). Hence, health services are summarized into spaces such as the consulting room, clinic, hospital, laboratory, where the individual is observed and assisted as a biological entity, where it is sough to reestablish the correct functioning of that part of the human body diagnosed as "damaged".

The urgency to recognize that human being is much more than a biological "circumstance" (not disregarding the greatness such thing implies), has caused another important trend of thought that, both theoretically and

methodologically approached health in terms of the social and historic contextuality that produces it in particular environments, and where the relations where it is originated are a circumstantial part of the individual's life and community (Ackerknecht, 1971; Conti, 1972); this trend is known as bio-psychosocial, and its main contribution has been to present health from a construction where the biological part is assumed, yet only to the extent that it is approached as the result of historical and cultural processes which generate specific ways to conceive health and consequently give way to "administration" manners that procure and attend it in our modern societies' sphere (Donati, 1994; Mora and Hersch, 1990; Rosen, 1985).

In this case, the work is clearly connected to the importance of exploring and exploiting fields of action and knowledge that have been put aside the making of public decisions in relation to health, and nevertheless, have a humongous potential that even if it is collected at the level of official documents, is excluded from the actions which everyday are carried out to meet the population's requirements on health services. This work is inscribed into the framework of a reflection that places health as an object of study of social sciences and where it is important to draw attention on the relevance that the sort of health's concept, which guides decisions and actions in this field, is determinant to manage financial and human resources, the sort of programs, and the definition of actions from which the different strategies of institutional action are developed.

In the current scenario of debate on health's issue, it seems to be that once again the particular characteristics of its acting in terms of the different actors and interests are being put aside and that at the level of the organizations' critical theory need to be considered in the framework of its economic, social and cultural references (Arellano *et al.*, 2000; Brito, 2000; Clegg *et al.*, 1998; Organización Panamericana de la Salud, 1997; Bañón and Carrillo, 1997). There is in the acting of the managers, administrators and bureaucrats a particular framework from which they interpret their function, labor and responsibility. Health is not a field of exception; hence, the way to conceive it as a biological disarray one of the axis upon which there has been established a set of health policies increasingly questioned from

the very interior of the governmental space, and for which this moment of change and transformation could mean an opportunity in the project of reorienting a work with the capacity to see in administration more than a neutral technological power, a social practice that faces different social actors and agents, trying to impose or preserve their conceptions on the ideal way to assist health issues.

Methodology

In order to develop this text, part of the fieldwork carried out with professional healthcare personnel from the Institute of Health of the State of Mexico (*Instituto de Salud del Estado de México, ISEM*) is retaken. It is three in-depth interviews with general surgeons, who have had chair positions, responsible for one of the programs framed in the first level of attention, and in particular in relation to the institutional program concerned to diabetes.

The fieldwork carried out in the framework of the research on "Family and diabetic patients", which is referred previously in this text, allowed identifying key informers (Alonso, 1999; Valles, 1999), who due to their formation and experience in the assistance of said ailment, as well as the knowledge they have on the institutional programs that at different stages of government (six-year periods) have been executed to assist diabetes, have abundant information on the approached subject.

The work with the key informers was based on an in-depth interview thematic guideline, which in each of the cases permitted the specific approach of the operation and functioning of the governmental programs that in the framework of the reform process assist the health problem diabetes represents. The thematic entries which were worked with were as follows: Reform and primary attention to health, Program of attention to diabetes in the framework of the reform, First attention level and formation of human resources in the framework of the reform, Reform and interdisciplinary approach to health problems. From these interviews' result we retake the narrations along with that exposed in governmental plans and programs, allowing the confrontation of the governmental discourse to the experience of those who enliven the quotidian health services.

In this sense, we also carried out a tracking and a documental analysis of the actions which have been defined in accordance with the plan of action and objectives of the Secretariat of Health, and that ISEM carries out as a response to the strategies which for the attention and prevention of diabetes are described in the national-reach documents, such as the "Modification to the Mexican Official Norm NOM-015-SSA2-1994. For the Prevention, Treatment and Control of Diabetes" (*Modificación a la Norma Oficial Mexicana NOM-015-SSA2-1994. Para la Prevención, Tratamiento y Control de la Diabetes*) (SSA, 2000a), and the "Program of Action for the prevention and control of diabetes 2001-2006" (*Programa de Acción para la prevención y control de la diabetes 2001-2006*) (SSA, 2001b). The revision of programs and official documents is incorporated, from where to establish an analysis line in respect to the administrative and organization circumstance that supports institutional attention to the diabetic patient, and which as a result from the reform suggests new work and intervention stages, which are necessary and important to know and analyze.

A first approximation to the way in which the so-called reform of the healthcare sector has impacted on the attention to the non-insulin-dependent patient[2] is offered, who is treated in the first level of attention of primary healthcare (aps); taking into account the stressed emphasis that official documents make on it, considering as the vanguard of a policy that, in the case of diabetes, could open the way to work strategies, both in the case of prevention and providence of a package of services which offers more than actions of the curative kind.

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[2] Clinically diabetes is usually classified in two large groups: insulin-dependent diabetes and non-insulin dependent diabetes. Most of the cases, between 80 and 90 percent, correspond to non-insulin dependent diabetes, which occurs in adulthood (after 30 years of age); however, recent studies give accounts of this ailment at earlier ages, being frequent registrations of children and adolescents who develop it. The case of insulin-dependent diabetes corresponds to people who suffer from bad pancreas functioning from birth, so they require different attention to that of the people whose insulin production is deficient and/or of poor quality. There are some other sorts of diabetes clinically described, and which require specific evaluation and treatment; there is for instance gestational diabetes. See SSA, 2001b and SSA, 2000a.

According to the established in the documents from the National Program of Health 2001-2006 (*Programa Nacional de Salud*), and that specifically deal with attention to diabetes (recognized as a serious public health problem), the services that in the first level have been designed to assist the problem include a wide range (SSA, 2000a; SSA, 2001b), going from detection of blood sugar levels and their corresponding periodical control to the process of medication that supported on pharmacological measures achieves the consecution of "normal" blood sugar levels; it is also considered the channeling of patients with complications to the respective specialists and medical subspecialties. In practice, each one of the strategies and levels of attention to the subject of diabetes faces administrative inertias that make the control of disease complex and difficult; and there are, likewise, restrictions of economic order that limit the reaches and expectations set in governmental plans and programs, taking into account that that which has been privileged by health policies, namely the clinical-pharmacological attention of diseases, against other relevant ways of working closer to education and promotion of sanitary and healthful measures (OMS, 1996; OPS, 2003), whereto no resources are destined neither are there formation of personal training programs.[3]

The process of reform (as a context)

In Mexico, the process of reform of the healthcare sector starts in the first half of the 1980's (1983), and it means an important restating not only of

[3] A recent exercise at primary attention level considers the organization of supporting groups called "clubs of diabetics", where as a result of work carried out in clinics by the medics, periodical sessions are held with groups of patients who are invited to attend meetings which acquire an informative character with experience interchange on the ailment, and how it is best handled as for non-pharmacological recommendations which turn out to be really supportive to control and prevent complications from diabetes. Nevertheless, the problem for this sort of exercises lies in the fact that there is not a commitment at institutional level, and frequently its functioning and organization is left to the initiative of the personnel in each of the clinics that, it is worth mentioning, faces a series of problems which make their operation difficult: lack of personnel, lack of organization and institutional support, need of spaces to hold the sessions, among other.

the national health policy, but also of the broadest scenario that represents the social policy of the country. It was a phase of the reform that by then was circumscribed to 14 out of the total of States part of the Mexican Republic;[4] likewise, it was marked by the permanence of control exercised from the center (federal government), on the nascent Secretariats or State Systems of Health, ever since it was attempted to operate a new manner to administrate attention and health services to the open population, that which does not have social security (Ruiz de Chávez and Lara, 1988; Cardozo, 1998; Moreno, 2001).

It is essential to point out that this stage , which is usually identified as the first of the reform, and where one has to insist on the fact that the change was very limited (mainly because of the power and control exerted from the federal instance of health), lives in 1995 a new moment that boosts the changes started in the previous decade. As part of the priorities stated by the National Plan of Development 1995-2000 (*Plan Nacional de Desarrollo*) during the period of Ernesto Zedillo the subject is retaken, with the intention of completing the project started in the previous decade.

For this second moment of the process, it was stated as important to recover the experience of those 14 States which took part in the first stage where the process was initially formalized. After slightly more than a decade of teachings, it was primordial the design of new decentralizing policies: from those of operative nature to those directly related to the new rules and financing mechanisms (Moreno, 2001). Therefore, having as a framework the National Agreement on the Decentralization of the Services of Health (*Acuerdo Nacional para la Descentralización de los Servicios de Salud*),

[4] Mexico is a country whose territorial-political division considers the existence of "States" as those entities which as a whole compose the political and territorial unit of the country. Therefore, it is in the second half of the 1990's (1996) when by means of the National Agreement on the Decentralization of Health Services all of the states and Federal District are incorporated into the process of decentralization. The fourteen states which take part in the first phase are: Aguascalientes, Baja California Sur, Colima, Guanajuato, Guerrero, Jalisco, México, Morelos, Nuevo León, Querétaro, Sonora, Tabasco, Tlaxcala and Quintana Roo.

published in the Official Bulletin of the Federation in September, 1996, work was oriented to provide greater responsibility to the States on the operation of their systems of health, at the time they enjoyed greater autonomy in the administration of their budgets. Ever since, it has been insisted on the role of federal authority must be limited to functions of normative and regulative nature; whereas, the responsibility for the providence of health services demanded by the population falls upon the different States, being in charge of introducing a renewed logic of work to meet the health requirements proper to each State.

It is necessary to remember that the discourse used to justify the reform process was basically centered on two postulations presented as inappealable. On the one side, the discredit of a public service that required a deep restoration capable of facing old and new challenges in the sphere of health; whereas in the economic one, the idea of a scarcity of resources that made indispensable its more rational and transparent use became stronger, which could be achieved from the strategies stated by the reform, decentralizing the attention of health toward the States of the country, and by the way facing a political conjuncture located in the framework of the so-called "new federalism" (SSA, 1994b; Torres, 1997).

Hence, for the case hereby analyzed, a first reading of the framework where the reform of the sector allows foreseeing the possibility of making the primary attention the ruling axis of a policy, which without putting aside the medical-hospital attention, rescues the disregarded potentiality of a first level which has witnessed a reduction of medical attention of ambulatory patients (SSA, 1994b; SSA, 2001a) in a clear and close concordance with the domination of a biological and clinical concept of the health-disease process (López, 2000). Nonetheless, after slightly more than twenty years of the beginning of the reform in Mexico, there are clear signals that health's primary attention is not and has not been a priority for the reform, since, as a matter of fact the policy on health still moves in function of a concept that demands the attention of the disease (biomedical model), whereto the flow of economic resources is destined, and toward the "most serious and structured" efforts to assist and regulate the administration prob-

lems that in this sphere are generated,[5] displaying the importance this manner of understanding health (in reality as attention to disease) has to define priorities and the operation of strategies that structure the services proper to this fundamental field of relation and social action.

First level of attention

In the field of social sciences, one of the most important traditions that validate the historical and social character of health is linked to the declaration by Alma Ata (1978), where primary attention is recognized in the referential framework of the social, political and economic, with a clear signaling as for the need for a paradigm change that recognizes the offer this attention level implies, where as it has been mentioned, the stating of health surpasses the preoccupation about assisting the disease, and destining the largest part of the economic resources to build hospitals in a growing level of specialization, both in terms of hospital infrastructure (state-of-the-art instruments and clinical methodologies) as well as personnel ascribed to them: specialized and sub-specialized medics, nurses, paramedic personnel, also with different degrees and levels of specialization (OPS, 2003; Bullough, 1985).

It is essential to distinguish the dominion which upon our society curative medicine has had, as the par-excellence reference to think of, talking, and acting in relation to health; it is indubitably, an implicit and explicit assumption on the realization of medicine as knowledge on disease and its sphere of action: the diseased people; in such manner that some authors have stated "this methodological and conceptual precision has probably been one of the reasons for the success of medicine" (López, 2000: 88-89).

[5] In this respect, the birth of the National Commission of Medical Arbitrage (*Comisión Nacional de Arbitraje Médico, CONAMED*) and the issuing of the Law on Professional Service of Career (*Ley del Servicio Profesional de Carrera*), both are destined to regulate areas and fields of institutional work that scarcely have to do with health's primary attention; nonetheless, at the same time show interest in offering certainty and clarity in the sphere of clinical medical acting, and of the responsibility which falls upon the direction levels and chairs of the very Secretariat of Health.

What is more, in a propitious context where institutional action presents clinics and hospitals as the place where reasonably and logically someone ill attends (and their family), looking for their recovering of anatomical and functional conditions socially recognized as health, and whose loss we call sickness (Conti, 1972).

Before the so-called curative medicine, there is another practice in the health sphere, which has been less recognized (identified) by the collectivity, and that in the scenario of reform of the healthcare sector seemed to recover: it is a sort of assistance that conceptually and in the practice is identified with the work in the first level of attention. This is thought to offer general medicine services to patients who do not require hospitalization; however and in a central manner, it has a task of prevention and promotion of health, despite in reality, the sort of attention it has been closely related along time is that the attention to ambulatory patient in the consulting room.

The high cost of a health policy that has privileged the construction of hospitals and fostered the development of medicine and its professional exercise in terms of the "need" for a growing specialization and subspecialization, as well as the incorporation of medications and medical material more sophisticated by the day, are on a one-way road, as there is not investment enough to meet a growing demand of hospital-medic attention, which besides is added the complexity proper to health problems. It is so, that in the stage of the neoliberal statements and the globalizing tendencies, one looks back at a first level of attention, whose low operation cost seems to fit very well to the expectations of a social policy that tries to place health in the private sphere and only under very particular circumstances, as a government's responsibility and its role facing society (BM, 1993; OMS, 1996; Laurell, 1997).

The problem is that we need to add to the already unviable health attention in terms of health, in curative terms (which always requires increasing investment) a context of important transformations in the field of worldwide economy, and which at the level of the Latin American region and in the specific case of Mexico has implied a fiscal adjustment that reduces the already historical low public budget on health witnessed in the

country (SSA, 2003; Arredondo *et al.,* 2004). Likewise, we need to underscore that such as it has been mentioned, the internal distribution of the budget on health (according to the level of attention) has been marked by the negligence toward primary attention, which has received the least of amount of resources, and similarly, where the lack of care in terms of formation and management of human resources; when, separately and contradictorily, one of the priorities defined in the current National Program on Health 2001-2006 is repeated in the discourse that in order to improve "equity, efficiency and quality" of health attention, it is essential to constitute teams able to provide an answer in accordance with the needs of population (SSA, 1990; SSA, 1994b; SSA, 2001a), so the pending work on the development, in terms of education, prevention and health's promotion is recognized.[6]

The case of diabetes implies a series of factors that in different spheres of life needs professional attention, not only a clinical doctor, but also another sort of formations (psychologist, nutritionist, sociologist, anthropologist, among other), which at a direct or indirect level support the patient in the course of a disease, and contribute to strengthen a new culture of healthcare among population. In order to operate the "innovative" approach, important changes at the organizational level of work are necessary, as well as in the perspectives from which the attention in the clinic and consulting room is offered to the patient, and obviously of the information and interaction task kept with the whole of population.

The "commitment" with the reform

The structural reforms, both economic and social, were accompanied by the introduction of new control schemas, assignation of functions, follow-up and evaluation of programs; which as a whole means that the ways, procedures and attitudes before work, either administrative or direct attention to the population that asks for medical-hospital services, was planned

[6] Institutional attention in health considers measures of preventive, curative and rehabilitating nature.

as substantially different in the new administration schema, where in terms such as "efficacy", "efficiency", "quality", "productivity", start to dominate a platform from which the importance and necessity of the changes introduced in the healthcare sector are presented and defended (Cardozo, 1993; SSA, 2001a; Homedes and Ugalde, 2002). The subject of health attention, as part of the polemic linked to human resources, becomes highly relevant as the change goes beyond the simple and mechanical reassignment of positions and tasks: it implies the reintroduction of a labor spirit, which at the time comes from that other great reform that at general level is settled in the sphre of public administration. We hereby refer to the "Administrative reform" (Cunill and Bresser, 1998; Bañón and Carrillo, 1997), which remits to the introduction of "innovative" management tools, according to the process of adaptation of the State to a scenario defined in terms of a neoliberal policy and the tendency toward a worldwide globalization.[7]

The new proposal was surrounded by an administrative dynamics that, for the present case, invariably remits to the search for quality of health services, and the meaning that primary attention apart from the individuals seems to rediscover the value of collective actions of the preventive kind. Hence, the importance of looking in a reflective manner the changes occurring in the attention of a disease that, as diabetes, requires a solid preventive unfolding, both to counteract the complications proper to the disease and to generate a culture of health among the population that lacks it.

It is feasible to affirm that from its origins, the lack of organization and coordination between the different government levels (to define the attri-

[7] By "Administrative reform" it is understood the development, introduction and use of new tools and procedures which in correspondence with the changes undergoing in the capitalist State must be introduced in public administration. Basically, it means to incorporate a series of strategies and instrument of work whose origin is to be found in enterprising management, hence the coinage of the term "Public management", which is the wing of public administration that dominates the process of change produced inside the instances and institutions of government in favor of improving the service and make work productive and efficient. See Arellano, Cabrero and del Castillo (2000).

butions, competences, responsibilities and participations in the new healthcare model) had negative impacts on the beginning of the reform, since lack of clarity pervaded all the levels and spheres of administration. As there was no direction and certainty on the particular sphere of responsibility, the reform seemed to take place aside from the very work carried out in the nascent secretariats or State Institutes of Health. In the particular case referred in this document, the work in primary attention of health has followed a logic different to the discourses and official documents, at least such is the perception of those who for years have worked for ISEM, and have knowledge on the way the reform has been present or absent in their immediate labor spaces; and in a similar manner, of the sense this has had as for attention to the diabetic patient. The interviews done to the medical personnel, with broad working experience in the first level of attention and particularly in charge of taking care of the diabetes problem provide the following information:

> It is enough to say that so far there are medical personnel, medical personnel I say, that does not know about the reform yet… I can tell; because of my job sometimes we go out to towns, we visit the jurisdictions and we find such things… and that has consequences, they are seen in the deficient work done on diabetes detection (González, 2005).

> There are surgeons, in general personnel as nurses, whoever… who work in clinics far from the city, who have not learnt about the reform, they only get to work, leave on time and they do not care about anything else, it is true that it is their responsibility to be informed because they leave an exemplar of the manuals and operative documents, but it is also a task of the people above to learn why this happens, and try to solve it (González, 2005)

One of the most severe criticisms to the reform is its lack of capacity and will to involve the actors of the healthcare sector into a project for which they represent a fundamental pillar; it is on the workers upon whom, in principle, the responsibility of giving life, carrying out the plans and work programs falls. Therefore, it is worrisome that attention to health, linked to the healthcare personnel's job, has not found a place in the agendas of those who make decisions on reforms. World Health Organization, through the Pan American Health Organization (OPS), has carried out evaluations

and follow-ups on the subject. The result seems to be the same for all the Latin American Region, the issue on human resources does not seem to exist as an important and basic place of the process of change (OPS, 1997; Brito, 2000; Brito and Granda, 2000; OPS, 2000; OPS, 2003), and even less if it is about educating and training personnel in the sphere of public health.[8]

In the case of Mexico, in spite of the insistence on each of the last three National Programs on Health (in the governments of Carlos Salinas de Gortari, Ernesto Zedillo and Vicente Fox Quesada), in relation to the importance of the personnel of the healthcare sector for the success of the proposed transformations, it is a fact the existence of large lacks that in terms of information and formation affect the project's consolidation, whose goals are impossible to reach without the collaboration and labor related to commitment, performance and objectives of the institution; hence, even nowadays, in the country there is healthcare personnel who does not know about the reform (Arjonilla, 2005).

It is distinguishable that facing the imperatives and challenges discussed in this field, talking about human resources still remits to the presentation of a listing, or a registration which gives an account of the total of medics according to their specialty, of the number of nurses by sort and degree of

[8] The possible explanation, not justification for this void, seems to be related to the political character of a labor reform boosted in society, and that in the case of health has supposed an open rejection from syndicates and associations of professionals, which identify in the reform a thread that fragments their power and negotiation capacity. Under a new management model of healthcare services, one must say that the subject implies the parallel use of double agenda; on the one side, the old agenda that must resolve "personnel" problems inherited from a model of fordist administration: stable and protected relations which guaranteed the permanence in the position; and at the same time, and given the most recent changes oriented toward economic and social transformation which enters into a crisis in the 1980's decade in Mexico becomes a burden to operate the State apparatus; on the other side, a new agenda marked by the necessity of a flexible work, this is, a regulatory model of labor characterized by the disappearance of the collective contracts, and the substantial modification of social perks, which at the time face the precariousness of labor, which disaggregate laborers fragmenting their negotiation capacity in favor of better wages and working conditions.

specialization as well, of the paramedic personnel (SSA, 2001a); when in reality, what must be dealt with in terms of the complexity implied in the organization and management of personnel from its most diverse facets: political, economic, organizational, trying to head the efforts to the achievement of institutional goals, and including a vision of administration with capacity to boost a change that is seen beyond organizational manuals and inefficacious lineaments (Arellano *et al.,* 2000), and which, on the contrary recovers the complexity they imply and which is produced in the organizations, leading a work where the values of service and transparency of the government's public apparatus are the column of the task to be performed.

Place and importance of prevention (public health)

The other great problem that affects the sphere of attention to the diabetic patient, and in particular the work at the first level of attention, has to do with the marginal place the institutions give to prevention and promotion of health; both in relation to the amount of resources destined for the attention of diseases, this is, the internal distribution of the expenditure on health, how it is used according to the level and sort of attention (SSA, 2003; Arredondo *et al*., 2004), such as in terms of the operation of education and training of human development programs.

> Primary attention is still the most unattended, there is no money, there is no recognition, no medications, no material to work with, there is nothing; looking no further, this building is full of leaks, primary attention and all "that" do not exist… so, how can results be asked? (González, 2005).

> […] here, with education, prevention and promotion of health, we are, I won't say exactly the same as when I started to work almost twenty years ago, but this work does not politically sells of that I'm sure; in the institution it is the least supported area (González, 2005).

This aspect has particular importance, as even if there is not an easy and automatic correspondence between the assigned amounts and the quality and efficiency of attention (retaking the discourse that surrounds and covers the reform), an open disregard to primary attention prevails; in such manner that in practice there is not congruency between a discourse that

appeals value and relevance of a work where to discharge the weights and economic implications of an exclusively clinical and pharmacological attention, which requires heavy economic investments (due to the cost of any sort of disease, its treatment and complications), and the total disregard primary attention suffers.[9]

Work on diabetes

In the framework of the 2001-2006 National Program on Health, the problem of diabetes as one of the federal government's priorities is retaken, developing specific sectorial actions to assist and prevent this ailment. Hence, the 2001-2006 Program of Action to Prevent and Control Diabetes becomes a central part of the strategies outlined to face the emergent problems, and before which there is an explicit definition of priorities, distinguishing activities related to health promotion, and early detection of diabetes. For this document's ends, it is important to underline that in this specific program, which sought to assist diabetes in terms of a public health problem, federal government emphasizes the necessity of a non-pharmacological approaching to the ailment.

> "Non-pharmacological treatment of diabetes will allow avoiding complications in the long term and broadening the use of services" (SSA, 2001b: 12).

It is recognized as well that this approach has niether been systematically applied nor as a priority, opting for the handling of the ailment and patient in terms of their diagnosis and treatment, based on clinical work and medications' prescription.

> Thus far, the non-pharmacological approach has not been regularly applied, it is common to immediately proceed to pharmacological treatment, because of this, in the official norm the criteria for its correct use is clearly stated (SSA,

[9] Obviously, costs vary depending on the ailment, however it is usually recognized that in the case of chronic-degenerative diseases the cost dramatically increases due to the complications and use of technologies (instrumental and pharmacological), as they are sophisticated and that, as a consequence, reach high prices in the market. In the case of diabetes, it is mentioned that this is the main causer of inferior limbs' amputations, as well as complications such as retinopathy and renal insufficiency. See: SSA, 2001b.

2001b:12).

At a first look, this intention to bring back from oblivion and disinterest primary attention in health could be interpreted as a possibility to restate the medical-biological paradigm where policies in the health sphere have been circumscribed to; notwithstanding in reality, and as we have exposed, there is an enormous breach between "the paper" and that which commonly occurs in relation to the treatment and approach of disease; among the workers from the healthcare sector involved in primary attention, clarity in respect to the idea of health that guides the government's decisions.

> If one reviews the last Official Report on the State of Affairs of the Governor, one realizes that when health is referred to, the construction of hospital is always mentioned, yet our work is seldom recognized, simply because it does not exist for politicians, neither does it for our chiefs […] education for health and prevention are just words, I can tell you the way things are here are the same or worse than before (González, 2005).

In the discourse delivered in the official sector there is blatant preoccupation to assist this ailment (diabetes), valuing a series of strategies proper to primary attention in health, underscoring that the reason that guides such decision does not only lies on economic impacts and consequences that the clinical-hospital attention of the ailment implies, but also the fact of remarking that in the field of prevention and collective work there is a real possibility to break the prevalence on the rise of the disease. In the Mexican Official Norm for the prevention, treatment and control of diabetes it is established:

> The programs of healthcare institutions for the prevention and control of diseases must include, as one of their basic components, the primary prevention of diseases (SSA, 2000a: 11).

Diabetes is a worrisome phenomenon in the international, national and local spheres, such as in the case of the State of Mexico, where the growing presence of an ailment that, following national trends, has displaced infectious diseases. According to the Program of prevention and control of diabetes mellitus of ISEM, in the year 2002, diabetes mellitus already held the first place as cause of death in the State (ISEM, 2005: 1-2); so in total

agreement with the national level the importance of "establishing an integral approach that strengthens primary prevention having as a base the control of risk factors…" is pointed out (ISEM, 2005: 1).

In spite the strategies and actions of attention and prevention of diabetes have become documents increasingly specific that try to channel and focus the efforts to attend the public health problem which for our societies implies the ailment's presence and behavior (SSA, 2000b), the approaches to clinics and hospitals give an account of the lacks we hereby refer to, and keep interfering in the exploration of intervention possibilities sketched on the plans and programs of health. It is a situation that really could be referred as "endemic", as it is indispensable to underline the historical contexts which are currently faced by the diabetes' attention and follow-up, it is a well-known fact, that after the reform, in terms of organization, there are new problems generated in the framework of the introduced transformations, and which have to be added the validity of the old vices and administrative handlings in the definition and delimitation of the work inside healthcare institutions. The new parameters, immerse in the statements and stakes of public management, do not seem to have solved problems dragged from the past, neither have they been able to solve the adverse situations born in the core of the dynamics of change that nourishes the process of reform.

> […] in reality, we the ones who assist the patient, are those who, as it is commonly said, "play the game". There can be all the documents you want, but we have to give answers and services right away… so far... er, my experience helps me best that anything else (González, 2005).

Bureaucratic schemes, which have seized the organization and the whole of society, have always ignored the richness and knowledge of the quotidian labor carried out by healthcare personnel, and in this particular case, the doctor, who must respond in the moment the patients' attention requirements.

Undoubtedly, for the case of diabetes, attention to patients and early detection as well as work in terms of prevention have been marked by lack of administrative coordination and economic resources; which in both cases

contravenes the aspirations and projects stated in the official documents. Indeed, another great prevailing problem, has to do with the assignation and distribution of the budget for health, which restricts the use of the State's resources to areas recognized as a fundamental part of their responsibility and acting before society.

> Yes, there are lineaments that establish that the patient must be given free medication, but it almost never happens because we regularly don't have it… (González, 2005)

> […] we regularly draw to donations and supports from pharmaceutical companies which as part of their products' promotion are always willing to support us, well… in this case they have always given us certain amounts of medications that we channel toward our "little patients" (González, 2005).

> […] many times there is not material to carry out the test, and some others, it is the doctor who simply does not do it, when it is known that as a regulation they are forced to carry out the test (González, 2005).

Finally, pointing out that the attention of the diabetic patient requires the concurrence of a work team, whose interdisciplinary staff is able to work with a synergic orientation in relation to the different recognized and presents ailment's facets. In addition to the figure of the medic, the informed and specialized labor of nurses, social workers, psychologists, nutritionists, anthropologists is needed; in this case, the channeling of the patient in function of the sort of complications witnessed in the ailment's evolution requires the support of cardiologists, ophthalmologists, podiatrists, among other.

What one finds in quotidian attention is the lack of work as a team; it is still the doctor's responsibility the attention of diabetes and in few cases where the participation of other professionals of health is observed, the constant complaint is marked by the prevalence of the doctor's authority (their biological vision of the ailment), which the rest of work and participants must be submitted to, professional participations which from the angle of nutrition, psychology, social work would have plenty of contributions to the non-pharmacological treatment of diabetes, and the very work that implies prevention and promotion of health so as to positively impact on

the population.

> Here the doctor orders and has the last word, other professionals, for example nutritionists, just like social work or nurses are to support our decisions and recommendations (González, 2005).
>
> I can tell you in this clinic… in the case of psychologists, this job is a benediction… for as far as I know one thing is the programs and all that there is to be read, and another is that in reality we have a job and the recognition of other professions different from ours… we have become arrogant because we know we have power (González, 2005).

Before situations such as those hereby pinpointed, it is difficult to think of reverting the behavior that in terms of morbi-mortality has register diabetes in the last quinquenniums; for, and in an alarming manner, there are variations in the behavior of the ailment, which make, for instance, the diagnosis occurs at increasingly early ages with consequences at micro- and macro-social as well as economic levels, because of all that which is represented at the level of the possibilities of personal and familial development, and in relation to the high cost of medical attention that no government is able to afford. The participation of social sciences in the spheres of health is still fractional, as it is seemed as unnecessary, or in the best of cases of little usefulness; so, in both circumstances it can be put aside. It is clear that if there are no resources to include the work of other professionals more closely linked to biological sciences (e.g. nutritionists), and there is not money to medically assist the patient, the case of an approach of the social and cultural condition of health problems seems to be much farther for the case of Mexico. That is why, despite the "preoccupation" of the institutions of health and the population about the incidence of diabetes in our society, everything seems to point toward the recrudescence of the problem in the years to come, strengthening as a worldwide pandemic.

As a final reflection

In the case of Mexico, public healthcare institutions do not make any serious effort to understand and analyze the nature, not only the clinical and medical ones, but also those other conditions of the social, economic and cultural kind that have conditioned the presence of the ailment. In this

sense, the reform process gradually loses weight and possibilities of work to favorably modify the population's health conditions, and especially to assists phenomena such as that of non-insulin dependent diabetes mellitus.

Work alone from a clinical perspective to assist diabetes, in terms of prevention, tracking and control is condemned to failure. Indubitably, there is the need for other sorts of approaches in order to be studied in terms of its social and cultural implications and to that extent proposing actions of the non-pharmacological kind that impact on the collectivity. The organization of healthcare systems should consider new perspectives of study and thus, be in conditions of offering the services that population demands. The current reform in the field of health can represent that opportunity of change, however, due the course the process has taken it seems difficult to be optimistic on the possibility that in the design of governmental policies, rather than assisting diseases, work on actions that procure and promote health begins.

It is indispensable to keep the reflection on a re-conceptualization of health beyond their biomedical approach, not only to enrich its analysis as an object of study, but also to strengthen intervention policies (governmental and non-governmental) that improve health conditions of broad population sectors in Mexico, in our case, and in the Latin American space.

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Sent to dictum: May 21st, 2007
Approval: July 2nd, 2007