



Program Budgeting for Health Within Mexico's Results- Based Budgeting Framework

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This case study was commissioned as part of the 2018 IBP-World Health Organization's joint paper on program budgeting in the health sector, **Program Budget Structure in the Health Sector: A Review of Program-Based Budgeting Practices in Low- and Middle-Income Countries**. Each case focuses on how a given country introduced and modified their approach to program budgeting over time, and the implications for the budget program structure under the respective ministries of health. While all case studies report on countries with budget programs, each country has followed a different approach (using different terms) to orienting their budget toward performance, of which their program budget and program structure is only one element. The cases, as well as the synthesis paper and related materials, are available here: <https://www.internationalbudget.org/analysis-insights/program-budgets/>.

INTRODUCTION

Mexico is a large upper middle-income country with a long history of program budget reforms. It also has, as is typical of much of Latin America, a fragmented health sector, with autonomous social security institutions providing health services to formal sector workers, while the *Secretaría de Salud* (Secretary of Health) is responsible for providing services to the rest of the population. While the Secretary of Health traditionally covered the informal sector through a national health service (modeled on the original National Health Service in the United Kingdom), this was reformed starting about 15 years ago with a shift toward a national health insurance model through the *Seguro Popular* (popular health insurance program).¹ Today, most of the population is covered by some form of social insurance, whether by the autonomous social security institutes that cover a majority of the population, or through the *Seguro Popular*, which now covers over 40 percent of the population.² Nevertheless, concerns about the quality and scope of insurance coverage remain, and in spite of increased public spending and a decline in out of pocket spending, the cost of health care still plunges millions into poverty each year.³

RESULTS-BASED BUDGETING IN MEXICO

Mexico has an elaborate system of “budgeting for results,” of which budget programs are an important part. Results-based budgeting is one of several forms of performance budgeting that attempt to link allocations to the achievement of specific results, such as outputs and outcomes of government services. In most countries undertaking such reforms, the budget presentation is organized around budget programs that represent the primary objectives of spending. These are broken down into sub-programs and activities that contribute to the

¹ Lakin, J. M. (2010) “The End of Insurance? Mexico’s Seguro Popular, 2001–2007”, *Journal of Health Politics, Policy and Law*. Duke University Press, 35(3), pp. 313–352. doi: 10.1215/03616878-2010-002.

² Centro de Investigación Económica y Presupuestaria (2018) *Sistema universal de salud: retos de cobertura y financiamiento*. Mexico City.

³ Centro de Estudios de las Finanzas Públicas (2017) *Evaluación Ex Post de la Reforma de la Ley General de Salud en 2003*.

objectives, and progress toward achieving objectives is tracked with results indicators. Mexico's budget program structure reflects the broader approach it has followed to implementing results-based budgeting in recent years.

Budget programs are not new in Mexico; they were originally introduced in the 1970s. Programs were revised substantially in 1996, and in the early 2000s the existing program indicators were reviewed and the number of indicators was dramatically reduced. In 2008, the country began a series of reforms to develop a modern performance budgeting system with a new program structure.⁴ Initially centering on the social sector, the approach soon spread to the entire government. In the period from 2010 to 2012, these reforms emphasized continuing to shift the budget away from what were known as "Priority Activities" and toward the current structure of budget programs.

In this period, the *Secretaría de Hacienda y Crédito Público* (hereafter the Secretary of Finance) and Mexico's largest public university, the *Universidad Autónoma de México* (UNAM) also introduced an online certificate program for public servants in results-based budgeting.⁵ A 2012 reform of the national budget law included the requirement that all budget programs follow a specific structure.⁶ In 2013, the Secretary of Finance introduced a new approach to performance indicators and targets, following the "logical framework" model.⁷ Ministries were also asked to connect their programs directly to the national development plan.

In 2015, Mexico had over 1,000 programs (including some that did not have a budget line in that year). While this was a significant drop from the figure in 2008 (1,574 programs), it was decided that it was still too many; many programs were duplications, or artificially split between different administrative units. A major revision was undertaken to reduce the number of programs, combining some and eliminating others, resulting in 851 remaining programs in 2016.⁸

⁴ Secretaría de Hacienda and y Crédito Público (Mexico) (2015) *Estructura Programática a emplear en el proyecto de Presupuesto de Egresos 2016*. Available at: http://www.hacienda.gob.mx/EGRESOS/PEF/programacion/programacion_16/1_av_PyP_Inv_ene_may_2015.pdf (Accessed: 31 May 2018).

⁵ <http://pbr2011.planeacion.unam.mx/>

⁶ Congreso de la Unión (Mexico) (2014) 'Ley Federal de Presupuesto y Responsabilidad Hacendaria', pp. 1–77.

⁷ The logical framework is a widely used tool for planning, implementation and evaluation. See https://www.unodc.org/documents/human-trafficking/Toolkit-files/08-58296_tool_10-3.pdf for an example.

⁸ Secretaría de Hacienda and y Crédito Público (Mexico) (2015) *Estructura Programática a emplear en el proyecto de Presupuesto de Egresos 2016*. Available at: http://www.hacienda.gob.mx/EGRESOS/PEF/programacion/programacion_16/1_av_PyP_Inv_ene_may_2015.pdf (Accessed: 31 May 2018).

PROGRAM BUDGETING IN THE HEALTH SECTOR

ORIGINS

The current set of health budget programs originated in previous structures that have been modified and streamlined over time. As noted above, ministries were scrutinized in 2015 and their program structures were tightened. In the health sector, the number of programs was reduced from 40 to 34, though this also included two new programs.⁹

Some of the changes made in 2015 followed a clear logic. For example, two different programs for capacity building of human resources in the sector were combined into one. A separate program financing infrastructure (E020) for Mexico's *Seguro Popular* was combined with the *Seguro Popular* budget program (U005). The maternal mortality reduction program (U007) and the reproductive health service program (P017) were fused to create the current maternal, reproductive and sexual health program (P020), justified in terms of bringing all major women's health initiatives into a single policy area.¹⁰

However, in the latter case and others, some government officials and civil society actors have suggested that the explanations for fusing or eliminating programs have not always been clear to them. Though extensive documentation is provided when a program is altered, it is not always obvious why a specific proposal has been made. A substantial part of the documentation in cases where programs are fused justifies the program overall, but not the decision to bring two or more programs together.¹¹

As mentioned above, the reengineering in 2015 did lead to an overall reduction in programs, but two new programs were also added: one for regulation of health facilities, and another for the defense of children's rights. The former program was introduced to better highlight the importance of facility oversight; the second to respond to the emphasis the presidential administration wanted to put on children's rights. While these programs were new, they did not cover new activities.

This suggests that new programs are often used to bring more attention and funding to areas that political leaders believe are not receiving enough attention within the complex structure of existing programs and indicators in the

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ See for example this "diagnostic" justifying the creation of the expanded women's health program P020: http://www.transparenciapresupuestaria.gob.mx/work/models/PTP/Reingenieria_Gasto/imagenes/Ventanas/Ramo_12/12P020.pdf

budget. In this case, both of these programs also responded to the creation of new organizational units focused on these issues (a new commission for oversight of health institutions, and a new prosecutorial office).^{12,13}

This very brief overview of the history of program development in Mexico indicates that while major targeted efforts, like the 2015 restructuring, can reduce the number of programs, there is a natural tendency toward fragmentation of the program budget over time. In addition to the new programs that were created during this attempt to tighten the program structure, two new health budget programs have been proposed for 2018-2019, one to focus on cancer, and another on transplants. These are recognized as areas of growing importance for the sector that deserve additional profile and financing. However, the Secretary of Finance did not accept an initial proposal to add these programs, arguing that the changes were not currently viable and requesting additional information to justify an expansion in the program structure. This indicates that some degree of control is exercised over demands for changes to the program structure.

TYPES, NUMBER, AND SIZE OF HEALTH BUDGET PROGRAMS

Mexico's health budget has a large number of programs in comparison with other countries. In the 2018 budget, there are 31 programs with budgets allocated to them.¹⁴

In part, perhaps, because many of the programs in the Mexican budget are legacies of earlier rounds of budget reform, these programs are of various types. Mexico uses its own typology of programs to categorize them, listed in Table 1. This table includes only program types used in the 2018 health budget; the full set of program types used in the Mexican budget can be seen in the planning and budgeting manual.¹⁵

¹²Secretaría de Hacienda and y Crédito Público (Mexico) (2015) *Estructura Programática a emplear en el proyecto de Presupuesto de Egresos 2016*. Available at: http://www.hacienda.gob.mx/EGRESOS/PEF/programacion/programacion_16/1_av_PyP_Inv_ene_may_2015.pdf (Accessed: 31 May 2018).

¹³ Detailed defenses of both programs are available at: http://www.transparenciapresupuestaria.gob.mx/work/models/PTP/Reingenieria_Gasto/imagenes/Ventanas/Ramo_12/12E04_1.pdf; http://www.transparenciapresupuestaria.gob.mx/work/models/PTP/Reingenieria_Gasto/imagenes/Ventanas/Ramo_12/12G00_5.pdf

¹⁴ There are three additional programs that are not reflected in the budget in 2018. The three programs that are not in the 2018 budget are K28 for feasibility studies (none budgeted for in 2018), B002 for production of chemical agents and vaccines (funded entirely from internally generated laboratory revenues), and W001 foreign operations, which is a "virtual" program that does not receive a budget and is used to account for activities of other state corporations.

¹⁵ Secretaría de Hacienda y Crédito Público (Mexico) (2018a) *Manual de Programación y Presupuesto 2018*. Available at: [https://www.gob.mx/cms/uploads/attachment/file/255203/Anexos del Manual de Programacion y Presupuesto 2018.pdf](https://www.gob.mx/cms/uploads/attachment/file/255203/Anexos_del_Manual_de_Programacion_y_Presupuesto_2018.pdf) (Accessed: 17 July 2018).

TABLE 1. TYPES OF BUDGET PROGRAMS IN MEXICO’S HEALTH BUDGET IN 2018

Program Class	Type
S	Subsidy programs with special regulations
U	Other subsidies
E	Public Service Provision
B	Provision of Public Goods
P	Planning and Evaluation
G	Regulation and Supervision
K	Investment Projects
M	Support to the budget process and institutional efficiency
O	Support to government administration and good government

This classification mixes what we might think of as economic classes with activities and objectives. For example, subsidy programs and investment projects are more related to economic activities than to the objectives of spending. On the other hand, service provision, planning, and regulation are more closely related to the purposes of spending. The decision to separate investment projects rather than integrate them with particular objectives (such as administration or public service provision) runs counter to the logic of program budgeting (and, indeed, counter to the earlier decision to bring capital spending for *Seguro Popular* into that program).

When we look at what these programs do, we will see that they are quite heterogeneous. *Seguro Popular* is an insurance scheme analogous to the independent social security institutes, each of which has its own budget and set of budget programs. A number of diseases or conditions have their own programs, such as HIV and diabetes. *Atención a la Salud* (Health Services) is carried out by high-level national facilities around the country. Formation of human resources and capital investment are treated as separate programs that do not contribute to the others. Some programs seem to relate largely to a single agency, such as the vaccination program or the protection against sanitary risks program, while others seem to involve a number of agencies, such as the health services program. This reflects the fact that some activities are naturally carried out by multiple agencies, but such multi-agency programs require more complex accountability structures than programs carried out by a single agency.

A challenging and somewhat problematic feature of Mexico’s program structure is that some of the programs are funding sources for others. In particular, *Seguro Popular* finances numerous other programs, including the vaccination program and the hospital services program. This means that the budgets for these programs do not reflect their full costs. For example, the budget for the vaccination program in Mexico (E036) only covers part of the funding for vaccines. This is not surprising: after all, part of the overall vaccine initiative in Mexico is run by the social security institutes, which are autonomous and have their own budgets. However, even under the Secretary of Health, the vaccination program (E036) does not cover the full vaccine budget; it is partly funded by *Seguro Popular*. The actual cost of delivering the Secretary of Health’s complete vaccination program is roughly twice as much as the budget for the *Programa de Vacunación* (E036), and the balance is funded by *Seguro Popular*.

This suggests a problem in program design, undermining both the transparency of the program budget and the ability of policymakers to use programs as a tool to prioritize expenditure across objectives. Mixing programs that carry out service delivery with programs that provide transfers or subsidies to other programs run by different agencies also makes the indicator structure (discussed below) less useful. The performance targets associated with the vaccination program in Mexico are the responsibility of the *Centro Nacional para la Salud de la Infancia y la Adolescencia* (The National Center for Infant and Adolescent Health, CENSIA), but, contrary to appearances in the program budget, *CENSIA* is not responsible for the entire vaccination program or its budget.

The financing role played by *Seguro Popular* is one reason why it takes over half of the entire Secretary of Health budget. It is also a very large transfer scheme, as it provides insurance for those not covered by the autonomous social security institutes and is run by the states. The next most substantial program is *Atención a la Salud* (Health Services), which takes another 16 percent of the budget. The third largest program in the Secretary of Health budget is a conditional cash transfer program known as “PROSPERA,” a health program for the poor, taking about five percent of the budget. This leaves around 23 percent of the budget for the remaining 26 programs budgeted for in 2017. In addition to the fact that *Seguro Popular* funds other programs, this variation in the nature and size of budget programs raises some questions about the extent to which they can be used as a tool to make tradeoffs and prioritize spending.

A final challenge posed by *Seguro Popular* is that it is an entitlement program and its budget is therefore determined by Mexico’s general health law, not by the budget process. The bulk of the resources for the program are based on a fixed per beneficiary contribution mandated by law. This raises a question of whether it should be included in the program structure alongside other programs whose budgets are determined differently. The presence of a large entitlement program tends to create the perception that the smaller programs are less important, but comparing these different types of program is not entirely fair or useful. The autonomous social security institutes have their own program budget structures, which suggest that some public budget prioritization happens within their overall budgets, and *Seguro Popular* could perhaps also be treated in this way.

Mexico does not use sub-programs in its program structure. In general, programs in Mexico’s budget process appear to be given less emphasis than the indicator framework. This seems to relate partly to the historical nature of the program structure and to the fact that it has not been possible to make major modifications to existing programs. This may have led to more focus on whether existing programs are delivering results rather than further elaboration of the program structure. This may also explain why, while there are no sub-programs, there are scores of indicators under the Secretary of Health, with many individual programs having more than 10 indicators.

Despite the lack of sub-programs, the Secretary of Health does use what are known as *programas institucionales* (institutional programs) to further break down budget programs internally for management purposes. The

National Center for Gender Equity and Reproductive Health, the responsible unit for the budgetary program related to maternal health, has six internal programs that correspond to its two budget programs of administration (M001) and maternal, sexual and reproductive health (P020). These six programs are: maternal health, breast cancer, domestic violence, gender, reproductive health, and family planning. In the interest of transparency, it would be prudent to make this structure visible in the budget by classifying the six as sub-programs, as their activities sometimes fail to correspond to performance indicators in the performance matrix and are therefore invisible.

PERFORMANCE INDICATORS

Mexico has an elaborate structure of performance indicators, with an impressive degree of supporting documentation online and available to the public. The evolution of this structure has been complex and reveals some of the strengths and weaknesses of Mexico's approach to results-based budgeting.

Initially, following the 2007-2008 reforms, ministries were asked to group all of their existing activities into programs and develop indicators using a hierarchy based on the logical framework approach. All programs have four levels of performance indicator, which are: *fin* (final goals), *propósito* (intermediate goals), *componente* (output), and *actividad* (activity).¹⁶ Government agencies were required to develop a program structure following this model, with activity indicators cascading upward to final goals.

Later, when six-year sector plans were developed under the current administration, including the PROSESA for the health sector (Programa Sectorial de Salud, 2013-18), program coordinators were instructed to ensure that the top indicators (final goals) were drawn from the sector plan. This ultimately undermined the logical framework approach used to develop the indicators, because the sector plan indicators are not all final goals and were developed through a distinct process. For example, the vaccination program (E36) has as its final goal the share of newborns receiving vaccines during their first year. But the intermediate indicators for this program are related to the degree to which children suffer from specific diseases which access to vaccines should prevent. Clearly, the sequence is wrong here: the delivery of vaccines is the specific activity the program undertakes that should lead to the reduction in disease.

In general, the attempt to link programs to plans is laudable, but as this example suggests, both the sequence of actions and weaknesses in the planning process have created challenges. Some agencies did not fully understand the health sector plan when it was developed, or were not fully engaged in it, and thus the indicators may not be the ones they would have chosen today. As a sector plan, with sector-wide indicators, the plan is also based on the

¹⁶ While there are slight variations in terminology and number of levels in logical framework models, the basic approach is to set up a series of cascading indicators that are connected logically and lead from inputs to final outcomes.

performance not just of the Secretary of Health, but of major autonomous institutions in the sector, like the social security institutes. These institutions are not, however, part of the Secretary of Health's program structure. This introduces a logical problem with using these indicators as the final goals for the Secretary of Health's programs.

Another area of both strength and weakness has been the review of program indicators by external evaluators, *Consejo Nacional de Evaluación de la Política de Desarrollo Social* (CONEVAL, the National Council for Evaluation of Social Development Policy) and the *Auditoría Superior de la Federación* (ASF, the supreme audit institution). To be sure, this is one of the strengths of the Mexican system: checks and balances within government create some degree of horizontal accountability that ensures that the program and indicator structure is subject to continuous review. Both institutions provide detailed feedback that is publicly available on the quality of program structure, the use and measurement of indicators, and the program's performance.¹⁷

On the other hand, in some cases, evaluators may not understand the sector well enough to give informed views on indicators, and their suggestions sometimes cause the indicator framework to move further away from the underlying logical framework. From time to time, there may also be conflicts between the findings of multiple bodies engaged in evaluation, which can create confusion.

In order to address information overload, and as part of the overall performance evaluation system, the Secretary of Finance has introduced a *Modelo Sintético de Información de Desempeño* (Synthesized Performance Information Model) to bring together various types of indicators into a single score for each program. Since 2013, programs have been ranked using this system from zero to five.¹⁸ Among the indicators included are those that emerge from external evaluators contracted to review program performance. Agencies are required to respond to these external evaluations, and they do so through proposing *Aspectos Susceptibles de Mejora* (Aspects Susceptible to Improvement). These include measures to improve the way programs are designed and how performance indicators are measured. Ministries develop plans to implement these measures, and are then monitored by CONEVAL on their progress.¹⁹

One final aspect of Mexico's approach to indicators speaks to the political incentives around using performance information. Among other responsibilities, CONEVAL publishes the official measurement of poverty in Mexico, which is measured using a multi-dimensional approach that includes access to health services. Over time, CONEVAL has been successful at publicizing the performance of this indicator, which often earns attention from

¹⁷ Audit findings from performance audits can be viewed at <http://www.asfdatos.gob.mx/>. To cite one relevant example, in 2016, the ASF raised a query about why the denominator for an indicator related to the accreditation of medical facilities had been reduced from 1178 medical establishments to 700 (which obviously would raise the rate of accreditation for the same number of facilities accredited).

¹⁸ See http://www.transparenciapresupuestaria.gob.mx/es/PTP/Dependencia_o_entidad#MSD.

¹⁹ See for example the documents on this page: <http://dged.salud.gob.mx/contenidos/deppes/asm.html>

the media and civil society. In part due to its salience with the public, both national policymakers and state governors pay attention to this indicator and seek to identify and fund budget programs that effectively reduce poverty. Every year, CONEVAL submits to the Secretary of Finance an assessment of the budget programs that it considers to be highest priority for funding based on their contributions to reducing poverty, and this submission does receive some attention from the executive during the budget process.²⁰ This is an example of how the use of performance information can align with political incentives in a way that can lead to greater use of this information, as well as greater equity in budgeting.

REVISING THE PROGRAM STRUCTURE OVER TIME

While there is a political and economic logic that tends toward the multiplication of programs over time (and in many cases, changes to their names), there is still a process that must be followed for proposing new programs that involves a rigorous diagnostic tool. This tool is based on the logical framework approach and requires ministries to consult external studies that identify a problem to which the program responds. Ministries must also clearly identify the target population for the program, including its demographic and socioeconomic characteristics.²¹ Thus while line ministries are given some room to argue for the program structure they would like, changes and particularly expansions in the number of programs are now reviewed and controlled.

While agencies in Mexico are discouraged from frequent changes to their program structure, Mexico does encourage regular review of existing programs, such as through an annual evaluation plan. The evaluation plan is a joint initiative of the Secretary of Finance and CONEVAL that requires external reviews of a subset of all budget programs each year, involving multiple types of evaluation, including program design and impact.²² For example, in 2018, the plan includes a “process evaluation” of the maternal health program, which should review its performance indicators.²³

²⁰ CONEVAL (2017) ‘Consideraciones para el Proceso Presupuestario 2018’. Available at: https://www.coneval.org.mx/Evaluacion/IEPSM/Documents/Consideraciones_para_el_proceso_presupuestario_2018.pdf (Accessed: 31 May 2018).

²¹ SHCP y CONEVAL (Mexico) (2016) *Aspectos a considerar para la elaboracion del diagnostico de los programas presupuestarios de nueva creacion*. Available at: https://www.coneval.org.mx/Evaluacion/MDE/Documents/Oficio_VQZ.SE.026.16.pdf (Accessed: 25 April 2018).

²² SHCP y CONEVAL (Mexico) (2018) *Programa Anual de Evaluación de los Programas Federales y de los Fondos de Aportaciones Federales para el Ejercicio Fiscal 2018*. Available at: https://www.gob.mx/cms/uploads/attachment/file/298756/PAE_2018.pdf (Accessed: 25 April 2018).

²³ Secretaría de Hacienda y Crédito Público (Mexico) (2018b) *Modelo de Términos de Referencia para la Evaluación de Procesos*. Available at: http://www.transparenciapresupuestaria.gob.mx/work/models/PTP/SED/Documents/Modelo_TdR_Procesos_SHCP_2018.docx.

LEGISLATORS AND THE PUBLIC

The creation and revision of programs involves back and forth discussions between the Secretary of Finance and the Secretary of Health. In general, no other actors are directly involved in this process. Mexico's Congress does use the program structure to direct funds to areas it deems particularly important, but generally has not pressed for the creation of new programs or indicators. Broadly, the Mexican Congress does not use the performance information included in the budget. This does not mean that they do not amend the budget: in 2018, Congress increased the budget for two health programs: health services, and maternal, sexual and reproductive health.²⁴ However, no public information is available to explain why they made these changes.

In 2016, the Secretary of Finance led a government-wide public consultation on existing indicators. Citizens (especially civil society organizations and educational institutions) were encouraged to download the existing indicator/target matrix and submit comments.²⁵ The government received over 200 submissions and used them in subsequent discussions with agencies about revising their indicators. This incipient attempt to involve the public in the determination of performance indicators is unique and is something other countries could potentially learn from.

PROGRAMS AND ORGANIZATIONAL STRUCTURE IN MEXICO

Most programs under the Secretary of Health have multiple organizational units that are responsible for delivering their performance. For example, the "Atención a la Salud" program delivers facility-based health care services. The program is overseen by the *Comisión Coordinadora de Institutos Nacionales de Salud y Hospitales de Alta Especialidad* (the Coordinating Commission of the National Institutes of Health and Specialized Hospitals), a group responsible for 21 institutions that contribute to its ultimate goals, such as reducing the rate of death from breast cancer.²⁶ While it is the responsibility of each program's "responsible unit" to ensure that these additional units perform as per the indicators, this is clearly a massive task. The responsible units (e.g., the Commission) do not have direct control over the budgets of each of the institutions that contribute to their programs. There is therefore no formal procedure for ensuring compliance with program targets.

However, the Commission does use performance measures to manage internally. It has a thick volume of indicators it uses to monitor high-level institutions under its remit that go beyond those included in the indicator

²⁴ Instituto Belisario Domínguez, D. G. de F. (2018) *Recursos destinados al Sector Salud en el Presupuesto de Egresos de la Federación 2018*. Available at: <http://bibliodigitalibd.senado.gob.mx/handle/123456789/3177>.

²⁵ Secretaría de Hacienda y Crédito Público (Mexico) (2016) 'Consulta pública para incorporar participación ciudadana a la definición o adecuación de indicadores del desempeño'.

²⁶ See detailed indicator matrix here: http://www.pef.hacienda.gob.mx/work/models/PEF2018/docs/12/r12_oimpp.xlsx

matrix published with the budget.²⁷ It has also used this document to push for changes to the budget program indicators as well, and was able to include a new indicator related to the effectiveness of the referral system in 2016.

PROGRAMS AS A MECHANISM FOR APPROPRIATION, CONTROL AND ACCOUNTABILITY

Mexico uses the program structure to appropriate funds and the national budget law regulates changes that may be made during the year to the distribution of the budget across programs. The law establishes two types of reallocation: external and internal. External reallocation requires the Secretary of Finance to sign off on the proposal, but internal reallocations may be done at ministry level without Finance sign-off. Program Class S is the only type of program that is considered external by law; all other program allocations may be modified during the year by the Secretary of Health (in this case). However, these modifications are also subject to limitations based on other forms of classification. For example, changes to Class U programs (other subsidies) are restricted by a limitation on changes to economic categories such as subsidy programs or state transfers (which would, for example, limit changes that could be made to *Seguro Popular*, a U class subsidy program that makes state transfers).²⁸ The Year-End Report (cuenta pública) does show substantial changes at program level in 2017.²⁹

CONCLUSION

Mexico has made considerable progress toward a program-based, results-based budgeting framework in the last decade. This is most clearly visible in the care taken to develop its program performance indicator framework, and the transparency of budget and performance data. There is also evidence of a growing culture of performance amidst pressure generated by the supreme audit institution (ASF) and CONEVAL. In recent years the process of changing programs or introducing new ones has been tightened to control the fragmentation of the budget. Nevertheless, the health ministry has a significant number of programs, and these programs follow different logics; these inconsistencies make them less transparent and less useful for expenditure prioritization than they could be. The lack of sub-programs also means that certain priority activities of government are not visible in the budget. Future rounds of reform should consider continuing to refine the program structure.

²⁷ Comisión Coordinadora de Institutos Nacionales de Salud y Hospitales de Alta Especialidad (2016) *Catálogo de Indicadores de Atención Médica de Alta Especialidad*. Mexico City.

²⁸ Congreso de la Unión (Mexico) (2014) 'Ley Federal de Presupuesto y Responsabilidad Hacendaria', pp. 1–77.

²⁹ See <http://cuentapublica.hacienda.gob.mx/work/models/CP/2017/tomo/II/Print.I50.03.GFEAEPECFP.pdf>

ANNEX 1. INTERVIEWS

The author thanks the following for generously agreeing to be interviewed for this project, as well as respondents wishing to remain anonymous. No one other than the author is responsible for any errors of fact or interpretation.

1. **Mariana Campos.** Coordinadora de Gasto Público y Rendición de Cuentas. México Evalúa.
2. **Dr. Juan Luis Gerardo Durán Arenas.** Director General. Centro Nacional para la Salud de la Infancia y la Adolescencia. Secretaría de Salud.
3. **Dr. Gonzalo Hernández Licona.** Secretario Ejecutivo del Consejo Nacional de Evaluación de la Política de Desarrollo Social (CONEVAL).
4. **Dr. Simón Kawa Karasik.** Director General de Coordinación de los Institutos Nacionales de Salud.
5. **Dr. Manuel de la Llata Romero.** Director General de los Hospitales Regionales de Alta Especialidad.
6. **Mtro. Ricardo López Loya.** Director General Adjunto de Administración y Finanzas.
7. **Ing. Rubén Rivera Martínez.** Dirección de Coordinación de Proyectos Estratégicos.
8. **Judith Mendez.** Investigadora. Centro de Investigación Económica y Presupuestaria.
9. **Rolando Mendez.** Dirección General de Programación y Presupuesto. Secretaría de Hacienda.
10. **José Angel Mejía Martínez del Campo.** Titular de la Unidad de Evaluación del Desempeño. Secretaría de Hacienda y Crédito Público. Subsecretaría de Egresos.
11. **José Genaro Montiel Rangel.** Director General. Dirección General de Programación, Organización y Presupuesto. Secretaría de Salud.
12. **Lic. Felipe Guadalupe Morales Lopez.** Director de Integración de Programática Presupuestal. Secretaría de Salud.
13. **Mtra. Gabriela Morales Cisneros.** Investigadora. Dirección General de Finanzas. Instituto Belisario Domínguez. Senado de la República Mexicana.
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