The Danish Health System And The Health System Of The Fourth Transformation Government In Mexico: Similarities And Differences

Dr. Juan Manuel Lira PhD [1] ,
Dr. Ernesto Latapi [2]

[1]Physician, orthopedic surgeon.
Master in Health Services Administration
and Management.
D. in Governance and Public Management.
Former public official in the Mexican health sector
E-mail: liraorto@yahoo.com.mx
[2]Surgeon
Former public official in the Mexican health sector
E-mail: elatapi@att.net.mx

Abstract

The Mexican government, known as the Fourth Transformation (4T), has proposed to transform the country's healthcare institutions in order to create a healthcare system "like one of the best in the world, like the Nordic countries, like Denmark, which has a good welfare state." To this end, after the COVID-19 pandemic, Mexico has resumed the initial plan of free medical care and medicines for the population without social security through a new centralized model of medical care through IMSS-Bienestar. This paper analyzes the similarities and differences between the Danish and Mexican healthcare systems. Although there are similarities between the two systems, structural, social and cultural differences are unlikely to allow Mexico to achieve the standards of the Danish healthcare system by the end of the current administration. The countries with the best welfare states have developed through long and complex historical processes and in Mexico, the 4T government is beginning the construction of a new welfare state contrary to the neoliberal policies that dominated public life for many decades. The successes, problems, and failures of all the models in the world teach that there is no ideal model, so they must be analyzed and adapted to the reality of each country. Mexico has its reality and challenges, so the

construction of a counter-hegemonic health system has begun in the current administration, and its consolidation as a good, free and universal health system will be the responsibility of the following governments.

Keywords: Danish health system, Mexican health system, fourth transformation.

Introduction

In Mexico, with the triumph of a coalition of leftist parties in the 2018 presidential election, a new national project called: the "Fourth Transformation" (4T) of the country's public life began. The first historical transformation was considered to be Mexico's Independence from Spain in 1821; the second was the liberal Reform struggle for a secular State that led to the separation of Church and State in the Constitution of 1857; and the third was the Revolution of 1910, which culminated in a new constitution in 1917, progressive agrarian reform and the labor legislation (Otero, 2018). The 4T government is trying to generate a reformulation of the regime of power, outlining a transformation of the Mexican State and the establishment of a new political order, re-founding key sectors of government (Ortega, 2022).

In the health sector, at the beginning of the current administration, President Andrés Manuel López Obrador (AMLO) stated:
"The health sector is a disaster. Education is bad, but the health system is worse, so I will develop a plan because people are dying of a lack of medical care. The purpose is that there will be free medical care and medicines for the entire population" (AMLO, 2018).

To begin with the transformation of the health sector after decades of neoliberal policies, AMLO's government made a reform to the General Health Law, eliminating the so-called Seguro Popular, which provided funding for the care of the population without social security, replacing it with the Instituto de Salud para el Bienestar (INSABI), which would be responsible for the provision of medical services in the states of the Mexican republic by entering into adhesion agreements and transferring physical, human and financial resources to the newly created Institute (DOF, 2019).

Since the beginning of his administration, AMLO promised that Mexico would have a first-class medical service similar to that of Nordic countries such as Denmark or Sweden (León, 2018). Unfortunately, due to the COVID-19 pandemic, it was impossible to start with the transformation of the health sector through the newly created INSABI. Recently, the Mexican government decided to continue transforming its health sector by creating the Decentralized Public Organization, IMSS-Bienestar, which through a presidential decree, will provide medical attention to the population without social security (DOF, 2022a). With the creation of IMSS-Bienestar. President AMLO once again ratified that at the end of his administration, Mexico will have one of the best public health systems in the world as in the Nordic countries, such as Denmark, which has a welfare state (Government of Mexico, 2022).

With the health reforms being implemented by the Mexican government, is it possible for its health system to be one of the best in the world, like those of the Nordic countries or Denmark? Below, from the perspective of organization, governance, model of care, quality of medical care, financing and training of human resources, the study analyzes the similarities and differences between the health systems of Denmark and the health system proposed by the 4T government in Mexico.

Similarities and differences in the health systems

The Danish health system is framed within the Beveridge or public systems model, in which the State provides universal health services free of charge, except for drugs, where there is a co-payment, dental services and rehabilitation (Ministry of Health and Prevention, 2008). The Mexican health system is a "mixed" model, with a Bismarck model of social security through employer contributions for the population with social security, a Beveridge model of provision of medical services through the public system for the population without social security, and a private insurance model of health services (Sanchez, 2012).

Organization

Until 2007, the Danish healthcare system was decentralized. With the health reforms of that year, the system's organization was centralized administratively, especially regarding planning and regulation, while the system's operation continued to be decentralized to regions and municipalities (Olejaz, 2012). The

organization of the Danish health care system is currently divided into five regions and 98 municipalities, organized on three administrative levels: State, regional and local. The State has the overall regulatory, supervisory and financial function, while the five regions are responsible for hospital care, the municipalities are responsible for prevention and promotion, and the first level of care. Therefore, administrative centralization played an essential role in the COVID-19 response (European Commission, 2021).

Until September 2022, the health system in Mexico was decentralized in 32 states in its two aspects: the population with and without social security, which caused a fragmentation of the system. At the beginning of 2022, the 4T government started a voluntary centralization of the State Health Systems (SESA) towards the Mexican Social Security Institute (IMSS) through its program called IMSS-Bienestar. In the Strategic Health Program for Well-being, the Secretary of Health of the 4T government proposed a different organization for the public health model for the population without social security, with the steering role falling on the federal Secretary of Health, the provision of medical services in the first and second level of care in the IMSS-Well-being, and the third level in the National Institutes of Health and State Hospitals of High Specialty, while the contracting of inputs, human resources and medical infrastructure will be in charge of INSABI (DOF, 2022b). During the COVID-19 pandemic, the administrative and operational centralization of the Mexican Health System played an important role in the organization of the response to the epidemic (Diaz & Ramirez, 2022). For the population with social security, the government of the 4T did not propose any organizational modification, and decentralization persisted in the 32 Federal Entities.

Governance

According to Diaz et al. (2022), Denmark's health system's governance occurs at different levels.

State Level:

Through the Ministry of Health, the State has a guiding role in the organization and management of regional and municipal health care, as well as the supervision and partial financing of the municipalities and regions.

Responsibility for legislation and providing general guidelines for the health sector lies with the Ministry of Health. Each year, the Ministry of Health, the Ministry of Finance, and the regional and municipal councils, represented by the Danish Regions and Local Government of Denmark, participate in a national budget negotiation to set targets for healthcare spending. The National Board of Health, attached to the Ministry of Health, is responsible for supervising health personnel and institutions and advising the regions and municipalities on health issues. In addition, the National Health Board is responsible for planning the distribution of medical specialties among hospitals. The authorization for the commercialization of pharmaceutical products and the supervision of the pharmaceutical sector is also a function of the Ministry of Health.

Regional Level

Councils govern the five regions elected every four years. The State and the municipalities fund them. A board known as the "Danish Region" represents the five regional councils. Its members are appointed for a four-year term and reflect the political affinities of the 205 members of the five regional councils.

The regions own and operate hospitals, prenatal care centers, and community psychiatric units and finance general practitioners, specialists, physiotherapists, dentists, and pharmacists. Reimbursements for private physicians and salaries for employed health professionals are agreed upon through negotiations between the Danish regions and the various professional organizations. The Danish Ministry of Health, Ministry of Finance and Local Government are also involved in these negotiations.

Municipal Level

The 98 municipalities are governed by councils elected every four years (elections are held at the same time as regional council elections). They provide first-level care services through general practitioners, nursing homes, home nurses, health visitors, school health care, municipal dental care, health prevention and promotion, and school health. These activities are financed by taxes, with funds distributed through global budgets and carried out by salaried health professionals. The local Danish government and various professional organizations negotiate salaries and working conditions.

Private sector

The private sector includes pharmacies and general practitioners; other self-employed health professionals include specialist doctors, physiotherapists, psychologists, and chiropractors. There are also private for-profit hospitals, which account for 2.5% of all hospital beds in the country. They are financed by private insurance. Some see the resulting differences in treatment access as a threat to the principles of equity in the Danish healthcare system, while others claim that they offer a good complement and an innovative element.

In the case of Mexico, the Ministry of Health of the government of the 4T has given guidelines for the governance of the care model for the population without social security (DOF, 2022c)

State Level

The Federal Ministry of Health will strengthen its guiding role through priority plans and programs for medical care and public health and will dictate public policies aimed at the social determinants of health. The Ministry of Health will be the health authority that guarantees and monitors comprehensive care in any healthcare institution or program and will coordinate so that health protection and promotion, prevention, cure and rehabilitation function adequately in medical care, public health and social assistance services. Additionally, the Ministry of Health will have greater control over the financial resources of federal origin destined for public health actions.

The National Public Health Service (SNSP) will be the operational arm of the Ministry of Health, composed of public officials deployed throughout the national territory and organized to implement and execute the essential functions of public health in the Federal Entities.

Health Coordinating Centers for Wellness will be operated under the stewardship of the Federal Health Secretariat to ensure continuity of care by integrating levels of care, from the community level to the most specialized level, through Integrated Health Networks (RISS).

The National System for Regulation and Health Promotion, coordinated by the Federal Commission for Protection against Health Risks (COFEPRIS) and its state counterparts, will continue to have the role of authorizing the marketing of pharmaceutical products and

supervising this sector, as well as other structural environments that are determinant for health.

Federal Entity Level

In the 32 Federal States, the Well-Being Health Care Model (MAS-B) will have to be applied; initially, its application will be voluntary. In the case of second and third-level hospitals, IMSS-Bienestar will be in charge of their administration and operation, as well as of Primary Health Care at the first level of care; in the case of third-level care, it will be the responsibility of the State through the National Institutes and High Specialty Hospitals. All the institutions that make up the National Health System must coordinate and articulate to guarantee the continuity of health care services through the exchange of services between public institutions.

Municipal level

The District of Health for Well-Being (DSB) will be the basic territorial unit of operation and functioning of the National Health System; its operational deployment is municipal; however, its governance corresponds to the coordination between the Federal Health Secretariat and the State Health Secretariats of the 32 Federal Entities. In this District, first-level medical care, public health and community care services will be provided.

Private Sector

People who can pay seek care in the private sector through private insurance plans or out-of-pocket payments. However, so do those with low incomes, even though they may have some public health schemes. Approximately 7% of the Mexican population has private health insurance coverage; however, out-of-pocket spending is 50%. In its new governance approach, the Federal Health Secretariat mentions the establishment of alliances with the private sector at the level of the Federal States to pool material and human resources for the benefit of the population's health.

The Care Model

The model of care in Denmark is mostly welfarist which has focused more on curing diseases and improving advanced medical treatment and less on the prevention side (Ministry Health Denmark, 2017) (Figure 1). Primary health care is provided by general practitioners who provide medical care at the first level and prevention and health promotion at the local level. All citizens can choose between two

types of care: 1) through a specific general practitioner who is part of the public health system where care is free, as well as if the general practitioner refers to a specialist, either public or private, and 2) through private health insurance where the patient can receive medical care from any general practitioner and can visit private specialist doctors without being referred by his doctor, but the services are subject to a co-payment. Ninety-nine percent of Denmark's citizens opt for the free public system. General practitioners occupy a key position in the Danish healthcare system, each doctor has an average of 1600 patients under his or her care, and it is through them that the referral of patients for specialized hospital care is controlled, which is provided in hospitals that are administered by the regions, if the waiting time for an examination or treatment exceeds one month, the patient can in special circumstances, receive the necessary services in a private hospital. In addition, patients who have suffered an accident or acute illness can go without referral to the emergency department in public or private hospitals. Medications administered at the hospital level are free of charge, and those prescribed outside the hospital are subject to a co-payment. Dental and rehabilitation services are not free of charge, and there is usually a co-payment through private insurance. At the municipal level, there are private community pharmacies for the supply of drugs for the first level of care. Due to the population's living conditions, promotion and prevention actions are focused on specific programs: alcohol, tobacco, physical activity, mental health, sexual health, sun protection, school health, hygiene, healthy food and meals, obesity and drug abuse. The municipalities are responsible for home health visits, generally carried out by nurses.

In Mexico, the care model is conditioned to the type of insurance: the population with a formal labor condition is attended to by social security and the rest of the population by the public health system. It is in this group of the population without social security that the government of the 4T initiated a reform in the model of care that it has called the Model of Health Care for Well-Being (MAS-BIENESTAR) (DOF 2022c) (Figure 2), which is based on Primary Health Care and includes both the elements of care for individuals and the social and collective health determinants. The assistance includes diagnosis, treatment, palliative care and rehabilitation centralized through IMSS-Bienestar. At the same time, public health interventions for promotion and prevention at both the individual and collective levels will be the responsibility of the State Health Systems of the Federal

Entities, including community action interventions in rural and suburban and urban areas with high marginalization. Medical and rehabilitation care, the supply of hospital medicines and outpatient prescription of medicines at the three levels of care are intended to be free and universal. In 2020, the basic list of medicines was replaced by the National Compendium of Health Inputs, which aims to achieve equity in access by guaranteeing the unification of medical supplies in all public health institutions (Consejo General de Salubridad, 2021).

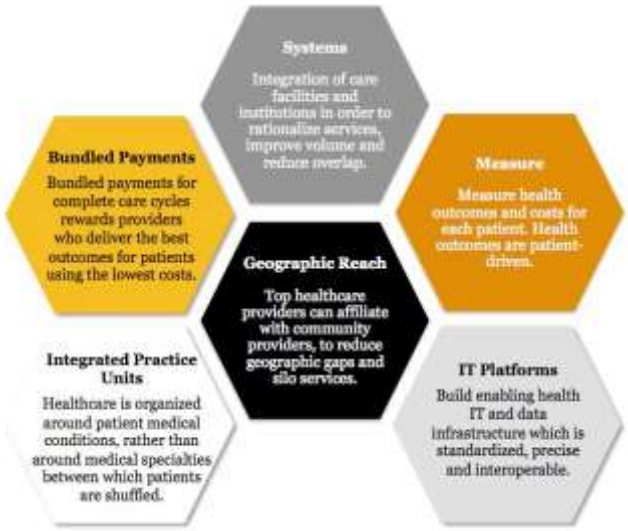

Figure 1. Model of care. Taken from Copenhagen Institute for Future Studies. Report on the future of the health care system in Denmark, 2018.

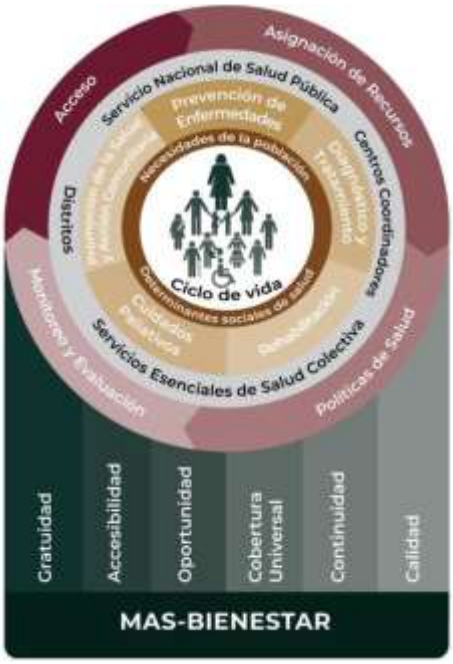

Figure 2. Model of Health Care for Well-being. Taken from the Decree issuing the Model of Health Care for Well-Being (MAS-BIENESTAR). Diario Oficial de la Federación November 10, 2022.

Quality of medical care

The Danish healthcare system has a Health Care Quality Program that sets national standards for quality in healthcare. The Danish Institute for Quality and Accreditation in Health Care administers this program, which is based on the principle of accreditation and standards and includes monitoring the quality of care in the primary and secondary sectors (Olejaz, 2012). The population in Denmark is actively involved in ensuring that the State provides highly specialized and high-quality health care using the best available practices (Moller, 2009).

The Mexican government's new care model establishes the implementation of a Quality and Safety in Care Management System with the participation of the population in the planning and delivery of health services, which will be in charge of the National Public Health Service, the operational arm of the Federal Health Secretariat (DOF 22022c).

Financing

The Danish healthcare system is predominantly financed by general tax revenues and, to a lesser extent, by local municipal taxes. The central government allocates subsidies to regions and municipalities based on their demographics and activity levels. The financing of the healthcare system is based on annual financial agreements between the governments, regions and municipalities. The parties agree on a set of targets for the level of healthcare spending on an annual basis negotiated between the government and the representative associations of regions and municipalities. All parties act as equal partners in these negotiations (European Commission, 2021).

The Strategic Health Program for Well-Being (DOF, 2022b) establishes the financing model for the new Care Model for the population without social security, which will be based on general and local tax revenues, without contributions or recovery fees for health services to the population, through three sources of financing: 1) Annual federal budget received directly by the Ministry of Health and IMSS-Bienestar from Branches 12 and 19 respectively, 2) Resources from the contribution fund between the Federal Entities and IMSS-Bienestar (regional taxes), and 3) Collaboration Agreements regarding the transfer of federal budgetary resources signed between the Ministry of Health, IMSS, INSABI and the governments of the Federal Entities.

Human resources training

The Danish Ministry of Health, the Ministry of Science, Technology and Innovation, and the National Board of Health are responsible for defining the training of health professionals according to the established health needs of their population. The State has control over the supply of health professionals, as the training of licensed health professionals in public. By regulating the capacity available for education, it is possible, to a certain extent, to control the number of authorized personnel within the different professional categories and specialties. Since the health care model is essentially a health care model, the training of human resources is more focused on specialized medicine (Olejaz, 2012).

The Ministry of Health of the Mexican government, through the SNSP, will be responsible for establishing guidelines for the training of human resources for health that will facilitate the organization, development and integration of activities in the national territory

following the proposed Model of Care. The training of resources must respond to the population's needs (DOF, 2022b).

Table 1 summarizes the similarities and differences between the two health systems.

Category	Danish healthcare system	4T health system in Mexico
Similarities		
Quality of care	Role of the State through an agency under the Ministry of Health	State functions through an agency under the Ministry of Health.
Financing	Through general and local taxes	Through general federal and local taxes (population without social security)
Differences		
Organization	Public or Beveridge system	Mixed system Public-Beveridge, Bismarck (social security), private
Governance	Operational decentralization, regulatory centralization	Centralized
Care model	Predominantly welfarist	Based on Primary Health Care*.
Resource training	In charge of the State in accordance with its model of care (welfare).	In charge of the State in accordance with its model of Care (APS) *.

Source: Own elaboration.

* Although the proposal of the 4T government's health system in Mexico is different, in practice it behaves similarly to that of Denmark (welfarist and centralized).

Discussion

Like other Scandinavian countries, Denmark has a solid and consolidated welfare state, and its health system is based on universal coverage and the principles of free and equal access to care for all its citizens. Under the above premises, the 4T government in Mexico tries to reach these welfare state standards through its policy of "free medical care and medicine" and the construction of a "universal health system," which is an appropriate path in a leftist and progressive government; however, beyond the rhetoric, some nuances must be considered.

According to Barba (2021), regimes and the consolidation of the best welfare states are built through long and complex historical processes that generate historical institutionalism and, in Mexico, the government of the 4T is initiating the construction of a new welfare state contrary to the neoliberal policies that dominated public life for almost four decades. In this sense, Altamirano et al. (2020) argue that fragmented systems that offer different benefits and levels of coverage according to the labor status of citizens have greater difficulty in achieving a full welfare state. Mexico has a fragmented health system, unlike Denmark, where its health system is not conditioned to the labor status of its citizens; therefore, in the remainder of the current administration, it will be difficult to achieve a health standard like the specific case of Denmark. However, Mexico has taken the first steps on the right path, although there is still a long way to go. After the containment of the neoliberal health policies implemented by the Mexican government, a period of transition and transformation of the implemented public policies is needed and then their subsequent consolidation, which could last at least two more administrations.

Denmark has a population of 5.8 million, while Mexico has a population of 130 million, so the challenge and complexity of providing health care to such disparate populations must be considered. In Denmark, close to 700,000 inhabitants live in rural areas, while in Mexico, nearly 25 million of its inhabitants live in rural areas (World Bank, 2021). That is why the health model and the training of human resources in Denmark are more focused on assistance (provision of hospital medical services) with less attention to the rural community. In Mexico, community care had a significant boom for many years through the IMSS-Bienestar program financed by the federal government; however, it lost strength in the face of the imminent medical-clinical (welfarist) approach that has prevailed up to the present time (Leal et al., 2021). In the current beginning of the federalization of the health system in Mexico, the medical-clinical approach of the Scandinavian countries continues to be privileged, leaving aside effective community action.

One of the key points of the good results of the Danish health model is its normative centralization and operational decentralization in regions and municipalities. In a properly structured system, it is necessary to balance the functions that should be centralized and those that should be decentralized. Normative centralization implies

stewardship: definition of general policies, elaboration and application of norms, methodology and general and common procedures that regulate the operation of each system, without prejudice to the adaptations that must be made at the operational level. Operational decentralization implies the capacity to manage human resources and the provision of services by public institutions at the local level, in addition to the fact that it must be carried out with a clear vision of the system as a whole (Zuleta, 2004 p. 6). It should also be carried out with a"bottom-u" vision: having the health team and the community at the system's center. In the Mexican government's process of federalization (centralization), these positive experiences should be considered.

Due to the characteristics of its population, the Danish healthcare model is more assistance-oriented than preventive and more focused on training human resources with medical-clinical profiles than on public health since its community assistance is reduced. On the other hand, the care model of the 4T government in Mexico (at least in its proposal) has a greater focus on Primary Health Care; however, the beginning of the centralization of the health system, the provision of services and the training of human resources follows a welfare logic favoring the clinical-medical path rather than the community care path.

There are similarities and differences between the health systems in Denmark and the ones promoted by the current government in Mexico. Experiences can be positive and negative, but each country should consider having a health system according to its social, political, geographical and cultural conditions. The successes, problems and failures of all the models in the world show that there is no ideal model, so they must be analyzed and adapted to the reality of each country. Mexico has its reality and its challenges, and its health system must be counter-hegemonic to the one inherited from past administrations and not try to be a "cop" of another model; however successful it may be, it can be a reference, the challenge is to have a Mexican health system of its own, and in this sense, if Mexico gives continuity to what has already begun and transforms it progressively and innovatively, through a balance between welfare and prevention, it will be on the way to having a health system that achieves a better state of wellbeing for all Mexicans.

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