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6 Health Systems Resilience and the COVID-19 Pandemic in Ecuador and Mexico

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Introduction

The COVID-19 pandemic highlighted the urgency of building resilient public health systems. The concept of global health security (GHS) and health systems resilience came to the forefront of public debates with the pandemic that began in the first quarter of 2020. GHS was introduced by the World Health Organization (WHO) to set guidelines for the measures that national governments should adopt to prepare for health shocks. The development of resilient healthcare systems was one of the core recommendations of the GHS normative framework. This chapter compares the level of resilience of the Ecuadorean and Mexican healthcare systems to examine how well they were prepared for a health crisis like the pandemic and how the first actions to respond to it unfolded, to contribute to the literature on national healthcare provision and global health policy.

Ecuador and Mexico are chosen as typical case studies of the Latin American region because, despite exhibiting important differences, they share significant similarities in terms of healthcare concerning institutional and provision configurations and modes of fragmentation. These cases can shed light on the key factors determining the responsive capacity of healthcare systems in the region and the challenges faced in terms of safeguarding adequate levels of protection and mobilising resources at the national and international levels. Healthcare provisions in both countries consist of Bismarckian social insurance programmes with an additional layer for people not covered by social insurance and a considerable role played by private providers, representing the most common types of healthcare organisations in the region. Like various other Latin American countries, these are two countries that have been devastated by the pandemic; at the beginning of 2022, Ecuador registered 194 deaths per 100,000 people, the eighth highest in Latin America, and Mexico 234 COVID-19 crisis deaths per 100,000 people, the sixth highest rate in the region (WHO, 2022). These cases thus evince the strain placed on typical Latin American healthcare systems and the consequences of the pandemic.

The comparative analysis of the two cases is based on the analytical framework of health systems resilience proposed by Thomas *et al.* (2020). The framework is made up of 13 strategies that governments should undertake to strengthen the resilience of their healthcare systems. Since at the moment of writing of this chapter, the pandemic was still unfolding and it was not clear yet what would be the results in many areas, the chapter centres on the analysis of the seven strategies that, according to the framework, should have been in place when the pandemic began, as part of the preparation of a healthcare system against any shock.

Our analysis is based on both quantitative and qualitative evidence drawn from national and international official sources, reports by non-governmental organisations, and academic literature. We aim to provide a comprehensive understanding of the actions undertaken in each of the strategies in order to inform our findings about the contradictions and lack of coordination of global policy. Our conclusions highlight the political processes that shape government responses to pandemics. We anchor our analysis on pandemic politics, as the possibility of building a resilient health system is a result of the actions and inactions of various international and domestic political actors who interact across multiple levels. We show how the actions of some international organisations may act against the building up of resilient health systems and how the Ecuadorean and Mexican cases can illustrate developments that unfold in all five areas of pandemic politics presented in the introduction of this volume, namely, symbolic politics, disease diplomacy, compliance with international regulations, medical populism and the political economy of disease.

The rest of the chapter is organised as follows. The following section presents the analytical framework of health systems resilience and justifies its application for the research. The second part describes the Mexican and Ecuadorean healthcare systems, including an overview of recent developments. Next, we analyse the actions undertaken for the seven strategies in both cases and compare their results. The final segment compares the findings of each case and offers some concluding remarks.

Global Health Security and Health Systems Resilience

The concept of GHS is defined by the WHO as the actions required to minimise the effects of acute health emergencies that endanger people's health across regions and international borders (WHO, 2021). The topic acquired a top priority in the early 2000s, given the imminent risk of the spread of zoonotic diseases among humans in a scenario of wasteful consumption and travel, the threat of biological terrorism, but mostly the consequences of the loss of biodiversity and ecosystem integrity. As a result, the WHO modified its International Health Regulations (IHR) in 2005, which established the rules to face acute health emergencies that may spread internationally or might require a coordinated international response. The 2005

IHR expanded the scope of activities that member states should undertake to detect and contain diseases at local levels, assess and alert the global community of disease threats, and prevent and control contagions (Rodier *et al.*, 2007; WHO, 2021).¹ Annex 1 of the IHR described the core capacity requirements of national health infrastructure to detect, report, and control health emergencies of international concern, but without mentioning links to any optimal organisation of healthcare services to address such events (WHO, 2021).

An additional resolution was issued in 2011 to establish guidelines for strengthening the capacity of health systems to address health emergencies (WHO, 2011). The resolution mandated member states to protect investment in health infrastructure and strengthen the resilience of health systems; to integrate health emergency management programmes into national health plans; to develop and prepare hospital infrastructure to respond to internal and external emergencies; and to strengthen local health workforces through enhanced planning, training, and access to adequate resources (WHO, 2011). Yet, this resolution still did not specify concrete measures that governments should adopt to deal with acute health emergencies.

The WHO monitors compliance with IHR with an annual self-assessment carried out by each country and voluntary external evaluations conducted every four to five years. According to this framework, in 2017, the implementation status of IHR core capacities for Ecuador was 90% and for Mexico 95%. The adequacy of this framework to assess the capacity of a country to address health crises should be questioned, since a large majority of countries registered high implementation percentages of IHR core capacities like these two countries but were subsequently harshly affected by the COVID-19 pandemic. Moreover, only one category relates to the actual provision of healthcare (WHO, 2021). A Global Health Security Index was published by the Johns Hopkins Center for Health Security and two other organisations to assess compliance with the IHR (GHS, 2021), with information for 195 countries but only one category related to healthcare provision. Hence, Thomas *et al.* (2020) may represent a more comprehensive framework to assess countries' capacity to face health shocks.

The concept of health systems resilience encompasses the set of actions that governments should undertake to prepare their populations against the growing risk of acute health events (Thomas *et al.*, 2020). In their policy brief endorsed by the WHO, Thomas *et al.* (2020) specifically define resilience as the ability to prepare for, manage, and learn from health shocks, in turn defined as sudden and extreme changes that impact health systems, like pandemics, economic crises, or political conflicts. This contrasts with the predictable and common emphasis on demographic or epidemiological transitions. The authors conceptualised a shock as consisting of four stages that form a cycle: preparedness to shocks, shock onset and alert, shock impact and management, and recovery and learning. They identified 13 strategies that

are required to enhance resilience during the four stages, classified according to the healthcare functions of governance, financing, resources, and service delivery to which they belonged (see Table 6.1).

The recommended governance strategies to have in place at the preparedness stage are effective and participatory leadership capable of preventing, detecting, and effectively addressing a public health threat with transparent communication, for which the building of trust and support and the existence of a legal mandate are fundamental characteristics; coordination of activities by relevant actors, which refers to the effective collaboration across sectors, state and civil society actors, as well as other governments and international organisations, to develop and implement adequate plans against health shocks; and effective information systems and flows, sharing critical information among stakeholders through functional communication channels involving hard infrastructure as well as the existence of freedoms of press and speech and the development of efficient surveillance systems.

For the financing function, the strategies for the preparedness stage are sufficient allocation and flexibility of monetary resources to ensure that the health budget is sufficient to meet demands and that it can be adjusted to face a health crisis; and comprehensive health coverage, with a generous package of services provided equally to the entire population, without which it will be challenging to adapt healthcare provision when a shock impacts the country.

Finally, the preparedness strategies for the resources function are the appropriate level and distribution of human and physical resources, like doctors, nurses, and other healthcare personnel, as well as hospitals and hospital beds, with the capacity of increasing them in case of a crisis; and a motivated and well-supported workforce in the resources function, who are found at the front line of the responses to health crises and are the most vulnerable in disease outbreaks.

The Ecuadorean and Mexican Healthcare Systems

This section discusses the healthcare systems in Ecuador and Mexico at the beginning of 2020. These two countries have been selected as they have similar healthcare systems, despite having different political systems and regimes, varying sizes, models, and levels of economic development. Both countries have healthcare systems of intermediate development among Latin American countries, established on Bismarckian principles with additional layers added later for people not covered by social insurance programmes. The private sector also plays a significant role in both countries. This analysis aims to identify the capacity and capabilities of healthcare provisioning to handle emergencies, especially those posed by the COVID-19 pandemic. We first provide a brief historical trajectory of both the Ecuadorean and Mexican systems to understand each respective state's ability to govern, manage, and deal with a crisis, following the approach of Mazzucato and Kattel (2020).

Table 6.1 Strategies to strengthen health system resilience

<i>Function</i>	<i>Shock stage</i>			
	<i>Preparedness</i>	<i>Onset and alert</i>	<i>Impact and management</i>	<i>Recovery and learning</i>
Governance	Effective and participatory leadership Coordination of activities across government and key stakeholders Effective information systems and flow	Organisational leaning culture that is responsive to crises Surveillance enabling timely detection of shocks and their impact		
Financing	Ensuring sufficient monetary resources in the system and flexibility to reallocate and inject extra funds Comprehensive health coverage	Ensuring stability of health system funding through countercyclical health financing mechanisms and reserves Purchasing flexibility of reallocation of funding to meet changing needs		
Resources	Appropriate level and distribution of human and physical resources Motivated and well supported workforce	Ability to increase capacity to cope with sudden surge in demand		
Service delivery		Alternative and flexible approaches to deliver care		

Source: Thomas *et al.* (2020)

The Ecuadorean System

Ecuador's public health system was initially established through the Social Security Medical Services in 1935 as part of the National Security System. It took several decades for the Ministry of Health to be created in 1967, during the state-led industrialisation period. This was done following the National Assembly's mandate to create a new constitution after three years of military dictatorship. At the time of its creation, Ecuador was the only country in Latin America without a Ministry of Health.

The Ministry of Health was created to provide universal coverage to the population. By 1970, it had completed its nationwide social infrastructure and became the primary supplier of health services to the Ecuadorian population, including remote rural areas. In 1970, the Direction for Health Promotion and Integral Health Attention was established, which oversaw coordinating attention, prevention, and promotion programmes.

In 1997, the Special Law for State Decentralization and Local Participation was introduced, delegating functions, powers, responsibilities, and resources, including financial ones, to municipalities to plan, coordinate, implement, and evaluate integral health programmes. However, most of the attention is still provided through the MSP network (47% of the medical units in the country) and the IESS network (10%).

In 1998, the health system was decentralised. Section 4, Article 45, of the 1998 constitution indicates that the state will organise a healthcare system that integrates all public, autonomous, private, and communal entities of the sector. However, due to administrative and political reasons, this decentralisation was not fully implemented, and the MSP (or Ministry of Public Health) kept its role as the main health provider. In the latest constitution of 2008, there was no mention of decentralisation in health (Goldman, 2009).

At the central government level, the MSP regulates health promotion through the National Directorate of Promotion and Integral Attention (OEA, 2016). The Public Health Ministry encompasses about 1,340 organisations, foundations, and associations directly involved in health promotion. Their participation is regulated by the Executive Decree No. 656 of April 13, 2015, as governed by the Sectoral Citizen Health Council (Lucio, Villacrés and Henríquez, 2011).

The healthcare system is organised into seven subsystems that add up to the Integral Network of Public Healthcare, or Red Pública Integral de Salud (RPIS): state-MEF-MSP (60.63%), IESS-SGSFI (23.20%), MIDENA-ISS-FA (0.87%), MDI-ISSPOL (0.85%), MDTOP-ANT-SPRAT (n/a), and a private for and non-profit (9%). These subsystems supply different packages to the populations they serve, under either the affiliate's or citizen/beneficiary's logic. Health services are provided through their network, across networks (since 2012), or by external parties working under the Complementary Network or Red Complementaria (RC), which are later compensated for providing health services. The RPIS, together with private providers, serves 90% of

the Ecuadorian population. The private sector coverage is hard to estimate, as people in the highest income groups are usually under-represented in the household surveys used to calculate health coverage (Lucio, Villacrés and Henríquez, 2011). In practice, the system is fragmented, as not all private providers collaborate with the public healthcare network. Doctors tend to be concentrated in big cities, which adds a layer of spatial segregation to the already uneven access to healthcare.

Coverage is highly segregated according to occupational status, which determines the levels of entitlements and provision schemes. Though the 2008 constitution explicitly states the state as a guarantor of universal insurance, there is no insurance scheme available to all citizens. The general social security scheme, IESS, provides entitlements to registered workers in formal employment, self-employed workers (autonomous), business owners, and non-remunerated family workers. Other insurance schemes, such as ISSPOL, cover the police and ISSFA, the army. The Farmers' Social Security (Seguro Social Campesino—created in 1968 and subsidised by the state) grants independent workers in agriculture and fisheries entitlements in terms of access to health, disability, and old-age pensions, thus serving rural populations. A Beveridge scheme based on taxes, for example, tax income and VAT, complements the System of Universal Insurance (Sistema de Aseguramiento Universal) based on contributions (Bismarck).

The Mexican System

At the beginning of 2020, the public system was made up of separate layers that offered coverage to different population groups, depending on the occupational status of the household's breadwinner. Several social insurance agencies provided coverage to different categories of formal sector workers; the two largest were the Mexican Social Insurance Institute (IMSS), which covered private sector employees, and the Social Security and Services Institute for State Workers (ISSSTE), which covered federal civil servants, plus special schemes for workers of the state oil company, the military, and employees of state governments. Social insurance agencies acted as both health insurers and providers of primary, secondary, and tertiary health services, funded by contributions from workers, employers, and the state. Each agency operated separately, with its own legal framework, administration, human resources, and infrastructure (González Block *et al.*, 2020).

For people not covered by social insurance, the creation of the National Institute for Health Welfare (INSABI) was meant to provide healthcare as a citizenship right. This population group is large for two reasons: the legal exclusion from IMSS mandatory social insurance of anyone without a formal employment relation, for example, the self-employed or employers, and because of widespread evasion of that mandatory insurance by employers and employees. In early 2020, INSABI had just been launched to replace a

health insurance programme that offered healthcare to the same population group targeted by INSABI, albeit on a voluntary basis and with the payment of contributions, although low-income families, which constituted the majority of the insured population, were exempt. Like social insurance schemes, INSABI functioned as a separate government agency that operated services with its own resources and infrastructure but was funded with general taxes and began operations only covering primary and secondary services (INSABI, 2020; Reich, 2020).

The private sector also plays a large role in the provision of healthcare services. Private services have mostly operated independently from public services with low levels of government regulation. In early 2020, public social insurance schemes could subcontract private services when their supply could not meet the demand for an intervention, and under IMSS legislation, the payment of health insurance contributions could be discounted if employers supplied healthcare services to their employees, but these options were scantily applied, and in fact the use of the second one had been in decline in recent years. Hence, the private healthcare sector has operated under a market supply and demand rationale, providing a wide range of services from primary care to highly specialised tertiary care. The deficient supply of public services across all schemes, worse in the case of services for people without social insurance coverage, explains the large role of the private sector; the poor quality and limited access of public programmes implicitly incentivises or forces many people of all income levels to use private services,² but with a difference in the type of service. Low-income people could only access private primary care, while interventions that require hospitalisations are only affordable to high-income groups (González Block *et al.*, 2018, 2020).

The federal Secretariat for Health (SS) is responsible for emitting public health measures and regulations of public and private healthcare provision. Each state also has a health secretariat, which coordinates the application of federal legislation in its jurisdiction. Until 2019, states' health secretariats were also responsible for administering the healthcare services offered by the Popular Health Insurance to people with no social insurance; from early 2020, INSABI sought to centralise those services, although several state governments did not sign the agreements to give up their services (Reich, 2020).

The General Health Council (CGS) represents another tier of public authority on health matters. This council is a collegiate body that is a direct dependency of the Presidency of the Republic, is presided over by the federal Health Secretary, and is integrated by the heads of several federal government departments and academic and professional institutions. The approval and publication of the declaration of health emergencies, as well as their management, are among the core responsibilities assigned to this body in the legislation. An executive board integrated by the Health Secretary, the IMSS and ISSSTE directors, as well as any other member designated by the president, has the responsibility of managing the cases of health emergencies (IGHS, 2021).

Strategies for Healthcare Resilience in Ecuador and Mexico

This section compares the strategies adopted in each country for preparedness against health shocks, according to the analytical framework proposed by Thomas *et al.* (2020). Seven strategies are analysed, belonging to the healthcare functions of governance, financing, and resources. The analysis covers the unfolding of each strategy up to and during the pandemic. We are particularly interested in discussing the health sector's capacity to perform emergency responses during policy design and implementation, thus the emphasis on aspects of governance (including effective and participatory leadership).

Resilience Strategies in Ecuador

Once the pandemic's epicentre moved to the region, Ecuador was soon identified as one of the countries hardest hit globally, next to Peru (*Financial Times*, 2020a). Nevertheless, the actual mortality is likely to be under-represented due to the scarcity of tests, the additional deaths from treatable diseases resulting from the limited access to intensive care units (ICUs), and the general collapse of the health sector in Ecuador. Various estimates of excess mortality in Ecuador, that is, the number of deaths above the historical average for a specific period as recorded in civil registries, show that the number of fatalities was higher than those reported by the government. In the middle of an infodemic, deferred responses, political fragmentation, fiscal constraints, and growing polarisation, Ecuador became an early global symbol of the devastating effects of COVID-19 (King *et al.*, 2020).

Effective and Participatory Leadership

On March 12, 2020, the government decreed an emergency in all health centres in the country affiliated with the National Health System, including laboratory facilities, units of epidemiology and control, air ambulances, medical and paramedical services, hospitalisation, and outpatient clinics. This Ministerial Decree directly responded to the imminent effects of the COVID-19 virus and aimed at preventing an outbreak. Following the declaration of COVID-19 as a global pandemic by the WHO on March 16, 2020, the government decreed a state of exception, given the exponential growth in the number of confirmed cases. The state of exception in practice meant limited mobility, that is, the freedom to transit and the right to free association and reunion, a strict restriction imposed to guarantee the observance of social distancing and quarantine measures. It also declared a curfew on March 17, 2020, while designating exempted groups whose mobility was permitted to assist in the public response to the pandemic, namely the National Police, Armed Forces, and health personnel. Thus, the state of emergency declaration was deemed necessary to coordinate the public response, mobilise the state's resources, and prioritise public expenditure. However, there was weak

coordination with subnational governments because of either inaccurate or incomplete data (Plan-V, 2020), poor enforcement of sanctions (El Comercio, 2020c), and a lack of harmonisation of policies and responses with municipalities (El Comercio, 2020a).

There was harsh criticism against the central and local governments for the noticeable lack of coordination. The first confirmed COVID-19 case was reported on February 29, 2020. Within a few weeks, and with a population of over two million inhabitants, the city of Guayaquil became the first COVID-19 hotspot. The government struggled to bury the dead while bodies were left in the streets of Guayaquil—not all attributable to the virus as tests were not widely available. A combination of collective panic, misinformation, and the collapse of burial services led to jarring images that made Ecuador infamous in global news outlets. By late March, the Municipal Director of Hygiene and Markets of the city announced the necessity to prepare a mass grave to bury about 300 bodies in Guayaquil (BBC, 2020), further exacerbating collective panic and discontent with the government's response.

Coordination with and among local governments was particularly challenging. Municipalities had a high level of independence regarding the type and strictness of containment measures. Tensions between the central and local governments resulted in a geographically differentiated and uncoordinated response. To diminish discretionary local responses, by early 2022, the central government, via the Committee for Emergency Operation (Comité de Operaciones de Emergencias, or COE), intervened and regulated the risk responses by creating a dashboard (Semáforo de Protección de COVID-19) that alerted the public of the level of cases per municipality and province and standardised the measures to be adopted according to the severity of the situation.

Coordination of Activities Across Government and Key Stakeholders

During the first weeks of the pandemic, there was weak coordination with subnational governments, either because of inaccurate or incomplete data (Plan-V, 2020), inadequate enforcement of sanctions (El Comercio, 2020c), or a lack of harmonisation of policies and responses among municipalities (El Comercio, 2020a). For instance, municipalities could determine the level of alertness in their territories and adopt containment measures such as lockdowns, depending on the perceived severity of the COVID-19 cases and estimated health response capacity. This resulted in ambiguities in risk assessment, with municipalities shifting the alert codes discretionally.

Regarding coordination with key international actors, before the pandemic, Ecuador had adopted the Cooperation Strategy 2018–2022, which determined the priorities of technical cooperation between the WHO and the Ecuadorian government to contribute to the objectives of the Development Plan 2017–2021 and the Sustainable Health Agenda for the Americas 2018–2030 (ASSA). Among the areas of cooperation, the emphasis was

on strengthening the National Health System to achieve universal access to health, the application of IHR, and attention to early mortality for chronic diseases and attention to vulnerable groups following a rights-based logic (intercultural and gender awareness).

During the pandemic, the WHO office in Ecuador coordinated with the Ecuadorian government and other organisations, such as UNICEF, UNDP, CARE, and the Red Cross, among others, to establish basic technical norms. Among these, it is worth mentioning the Protocol for Intercultural Awareness for the Prevention and Attention of COVID-19 for Peoples and Indigenous Nations, Afro Ecuadorians, and Montubios in Ecuador (Protocolo con Pertinencia Intercultural para la Prevención y Atención de la COVID-19 en Pueblos y Nacionalidades Indígenas, Afroecuatorianos y Montubios del Ecuador) (Consejo Nacional para la Igualdad de Pueblos y Nacionalidades, 2020). It was implemented to approach community leaders to coordinate actions with public entities, particularly humanitarian aid and transport. Next to this, the Confederation of Indigenous Nations of Ecuador (Confederación de Nacionalidades Indígenas del Ecuador, or CONAIE) and the Confederation of Indigenous Nationalities of the Ecuadorian Amazon (Confederación de Nacionalidades Indígenas de la Amazonía Ecuatoriana, or CONFENIAE) adopted voluntary measures, such as self-quarantine within peoples and indigenous nations' territories and prohibiting activities such as tourism (Altmann *et al.*, 2020).

Effective Information Systems and Flow

Public information campaigns and protocols for the attention of vulnerable populations were set in motion in Ecuador during the pandemic. Nevertheless, according to a study by the Central University of Ecuador, only 39% of the population reported knowing the reasons why quarantine measures were set in place in the country (Altmann *et al.*, 2020). Also, as was the case in many other countries, there was controversy regarding the actual number of deaths attributed to the pandemic. While Sebastián Naranjo (2020), senior analyst at Cálculo Electoral, a data analysis group, reports a level 230% higher than the usual figures for April 2020—equivalent to 14,460 deaths—a *New York Times* Big Data analysis estimates that the mortality in Ecuador was 15 times higher than the official number of COVID-19 deaths reported by the government for the same period (*New York Times*, 2020). As of December 2020, Naranjo estimates a total excess mortality of 37,753, considering civil registry data for the period March 12 to December 17, 2020, when compared to historical averages for these months in 2017, 2018, and 2019, as obtained from the Statistics Department, INEC, and published by the Civil Registry (Registro Social). Yet Ortiz-Pardo and Fernández-Naranjo argue that these estimates, based on historical weekly or monthly mean values, were sensible to outliers and thus misleading. During the first phases of the pandemic, the country suffered from an “infodemic,” for the ambiguity

in the numbers led to either alarmist and politicised responses or aloofness and delayed responses.

Other intersecting issues started to surface as the pandemic progressed and information reached media outlets and civil society organisations. On March 27, the Committee for National Emergencies (Comité de Operaciones de Emergencia Nacional, or COE) released the Protocol for the Communication and Attention of Gender and Intrafamilial Violence during the COVID-19 Emergency (Protocolo de Comunicación y Atención de Casos de Violencia de Género e Intrafamiliar en la Emergencia por Coronavirus (COVID-19)) (COE, 2020). This protocol was drafted in response to the plea of women's rights activists who had highlighted the increase in gender violence, following the recommendation of the Follow-up Mechanism to the Belém do Pará Convention (or MESECVI) of the Organization for the American States (OAS). On March 31, the National Council for the Equality of Disabilities (Consejo Nacional para la Igualdad de Discapacidades, or CONADIS) (CONADIS, 2020) released a protocol for persons with disabilities and their families: Guide for the Prevention and Attention for the COVID-19 Exposure of People with Disability and in a Condition of Temporal Disability, and Their Families (Guía de prevención y atención por contagio del virus COVID-19 en personas con discapacidad y en condición discapacitante temporal y sus familias), which offers general guidelines to prevent the spread of COVID-19 while caring for persons with permanent or temporary disabilities, both at home and in the community, in particular, norms regarding hygiene and psychological health.

Ensuring Sufficient Monetary Resources in the System and Flexibility to Reallocate and Inject Extra Funds

The Ecuadorean healthcare system, due to limited fiscal capacity, had run large deficits and suffered from underinvestment, with shortages of workers prior to the pandemic. As of 2019, there was a deficit of about US\$3,655 billion (approximately 3.2% of GDP), according to Lucio *et al.* (2019). Domestic private health expenditure as a percentage of current health expenditure was 48%. Furthermore, the health system is vulnerable to shocks, given that the financing is heavily reliant on either formal sector contributions (which are pro-cyclical and limited given the high levels of informality) or the central budget, which poses evident liquidity constraints dependent on the business cycle, including the capacity of workers to contribute to the system through taxes and contributions and the reliance of government revenues on extractive rent.

The cutbacks in public healthcare expenditure were exacerbated by the International Monetary Fund's (IMF's) call for fiscal adjustment within the framework of the Extended Arrangement Under the Extended Fund Facility of 2019 (Naciones Unidas, 2020), including a significant layoff of public healthcare workers who could have supported the health response during the

pandemic (Naciones Unidas, 2020). However, the IMF provided funding to support the country's stabilisation and recovery programme: a US\$6.5 billion Extended Fund Facility arrangement on September 30, 2020. The new Extended Fund Facility of December 15, 2020, called for further fiscal adjustment equal to 5.5% of the gross domestic product (Progressive International, 2020). While the government failed to make US\$200 million in bond interest payments due to the health crisis, it still made a US\$325 million principal payment on its sovereign bonds due in March 2020 (*Financial Times*, 2020b) and reached an agreement with its bondholders on August 3, 2020 to restructure its US\$17.4 billion of sovereign debt (*Financial Times*, 2020c). The government had to navigate these external pressures in the face of strong opposition for prioritising debt servicing (CDES, 2020) and the possibility of significant social and political unrest—as alerted by mobilisations amid the restrictions in October 2020 (El Comercio, 2020b), echoing the 12 days of protests in October 2019 that followed the announcement of the end to a fuel subsidy and a series of austerity reforms recommended by the IMF as part of a plan to reduce public debt (Díaz Pabón and Palacio Ludeña, 2021). These external constraints further limited the public health response to the COVID-19 pandemic.

Universal Health Coverage

Access to the public healthcare system, as provided by the Health Ministry, or MSP, is based on both (registered) residency and citizenship. Yet, the actual capacity is limited. Most comprehensive health services are accessible only to those affiliated with the branches' social security systems: IESS, ISSFA, and ISSPOL (Lucio, Villacrés and Henríquez, 2011) or via private providers, as shown in Table 6.2.

Financing is organised through the National Health System, in which funding comes from taxes and state royalties (central budget) and is executed through fiscal transfers. Next to this, the National Insurance System is financed through social security (IESS, ISSFA, and ISSPOL) contributions. The system has been increasingly commodified, as health funding is increasingly channelled to the private sector. There are significant barriers to accessing health services. A significant share of the population is not affiliated with the social

Table 6.2 Healthcare coverage indicators of Ecuador

Percentage of population covered by government schemes and private schemes	12.2%
Percentage of population covered by social insurance schemes	IESS: 29.2%
Percentage of population uncovered	58.6%

Source: INEC (2019)

security systems, which results in staggering differences between different sectors, formal and informal. This results in non-covered populations resorting to private providers, when available, with ruinous out-of-pocket expenses. For example, in 2018, the out-of-pocket payments as a percentage of current health expenditure were 40% (WHO, 2021). With the public healthcare system overloaded with COVID-19 patients, many low- and middle-income and informal populations were left to their own means to secure access to health services, with an increase in the co-morbidity due to a lack of timely attention to otherwise treatable diseases.

Appropriate Level and Distribution of Human and Physical Resources

As of 2020, for every 10,000 people, the number/density of doctors was 23.44 and for nurses, 14.54 (as reported for 2018), while the number/density of beds in public, for-profit, and not-for-profit institutions was 741 surgery rooms, 369 delivery rooms, 205 ICUs, and 204 intermediate care rooms, also for 2018 (OIT, 2021). The system was evidently understaffed. According to an ILO study, in November 2020, the public healthcare system had only managed to provide medical attention to 60% of the patients covered during 2019, with the most significant reduction taking place in IESS-related hospitals, approximately 39% (OIT, 2021). There has been a significant effort to make use of virtual medical visits and expand remote outpatient care to serve the most vulnerable populations (those aged 60 and above). Furthermore, from the 4,165 in- and out-patient health centres, both public and private, only 626 could provide in-patient care (about 15%) (Observatorio Social, 2020). This means that even if these centres could diagnose COVID-19 cases, they did not have the capacity to hospitalise them, and among the latter, very few centres had an ICU.

In addition, these figures do not even consider the territorial and urban-rural divides, which played a role in the unequal distribution of COVID-19-related deaths, correlated to the unequal provision of human and physical resources across the country. Not only financial but also geographical barriers have impeded access to prevention, testing, and treatment of illness, particularly evident during the pandemic. The three largest provinces, Guayas, Pichincha, and Manabí, concentrate nearly 40% of the total health centres in the country, next to provinces in the Amazon region and Galapagos Islands that have a low density of health centres relative to the population. However, these provinces have the highest proportion of healthcare professionals relative to the total population, for example, Pastaza: 57 doctors and nurses per 1,000 inhabitants, indicating a mismatch between physical and human resources.

Motivated and Well-Supported Workforce

Emergency responses to deal with the pandemic in the context of limited resources resulted in a reduced ability to respond to other illnesses and

conditions. With health workers overworked and underpaid, the risk that exposure to viruses and other contaminants translated into fatalities among critical staff increased dramatically. It is estimated that between 2019 and 2020, nearly 3,000 (public) healthcare workers were fired and about 2,279 were made redundant during the pandemic (Palacio Ludeña, 2023). In addition, it should be noted that until late 2019, Cuba had been an important international actor in the health sector, under a bilateral cooperation framework that allowed for Cuban doctors' participation in health provisioning in the country. Though the central government introduced a series of incentives, both financial and non-financial, many hospitals were understaffed due to the continued cuts in personnel.

There was also an imbalance in terms of the proportion of doctors and nurses per medical establishment, resulting in the possibility of diagnosing COVID-19 cases but having to refer patients to other centres that had enough personnel.

Resilience Strategies in Mexico

Effective and Participatory Leadership

Mexico has been one of the countries most affected by the pandemic. The number of cases that are reported in official statistics results from the low levels of testing, much lower than in any comparable country. The real impact of the pandemic is revealed by other indicators, like the excess mortality rate from all causes of 55% during 2020 and the first semester of 2021 (OECD, 2021).

The leadership role in the government's response to the pandemic was assigned by the president to the office of the Undersecretary for Health Prevention and Promotion (UHPP). The CGS, established in the legislation as a collegiate body with a mandate to act and emit policies and rules in cases of health emergencies, has played only a minor or even insignificant role. The CGS was not summoned for the first time until March 19, more than one month after the WHO had declared the coronavirus outbreak a public health emergency of international concern, and it did not declare a health emergency due to COVID-19 until March 30. Even the Health Secretary played a secondary role to the Undersecretary. The outcome of the type of leadership that has been exerted has been the excessive centralisation and politicisation of decision-making, with dire consequences for the fight against the pandemic (IGHS, 2021).

The decision taken by the president to delegate authority to the UHPP could be understood as the need to optimise the management of the pandemic, but far from achieving that aim, it caused a number of problems that undermined the government's response. The centralisation of authority in a small department of the federal government obstructed the development of public deliberation and learning processes, crucial to formulating, adapting,

and implementing public policy in a challenging and dynamic environment like the one created by the pandemic.³

When the pandemic struck, the country was already experiencing unprecedented levels of political polarisation due to constant public attacks by President López Obrador against any actor who disagreed with the orientation of his policies. The head of the UHPP, Hugo López-Gatell Ramírez, who personally assumed the protagonist role, frequently put the blame on the pandemic and its impacts on other social and political actors, attacking anyone who questioned the government's decisions, creating recurrent political frictions that obstructed collaboration with other government levels and departments.

As a result of the type of leadership that was generated, decisions were made on political grounds and not on a technical basis, ignoring advice offered by various international and domestic governments, as well as academic and professional organisations.⁴ For example, no massive testing programme or serious contact tracing was ever introduced, and the federal government refused to recommend or mandate the use of masks.

Coordination of Activities Across Government and Key Stakeholders

The centralisation and politicisation of the federal government's pandemic response impeded the coordination with other government and non-government actors, which was fundamental to ameliorating the pandemic's negative effects. Notwithstanding the complexity of coordinating a response to a health emergency in a federal system of government, the leadership style displayed by the UHPP generated recurrent quarrels with other state actors. State and municipal governments were not considered for the formulation of the measures to face the crises, nor were they included in their implementation. For example, the traffic light system was designed without the participation of subnational governments, prompting many state governments to ignore or create their own monitoring systems (IGHS, 2021).

Coordination with other federal healthcare agencies, like IMSS and ISSSTE, seemed to have been close, which could have been expected as they are also under the direct authority of the president. Nonetheless, advice and suggestions to combat the pandemic from academia, civil society, or Congress were not only ignored, but their proponents were also labelled political adversaries and attacked on a political basis. The neglect of the CGS eliminated a space where adequate coordination could have been achieved and valuable knowledge to improve the response could have been exchanged (IGHS, 2021).

The private health sector was possibly the only non-governmental stakeholder with whom a relatively successful coordination was developed. Agreements were made early on to treat beneficiaries of public health insurance schemes in private hospitals, but they covered only seven interventions (SS, 2020).⁵ Moreover, the federal government showed contempt for private

providers when it refused to include many private health personnel in the first vaccination campaigns (IGHS, 2021), with dire consequences for these employees.

Effective Information Systems and Flow

Since 2006, the prevalence of respiratory illnesses has been monitored through a sentinel system that collected information from a national representative sample of health centres and hospitals across the country. The system was employed to monitor the development of the COVID-19 pandemic, but the decision to reduce the number of units of the sample and the particular characteristics of the new virus rendered it useless. The large number of infected people with mild symptoms or who were asymptomatic and did not turn up at health facilities disabled the system's capacity to survey the evolution of the number and location of cases and deaths and to serve as an instrument to plan actions to respond to the pandemic. Suggestions from a wide variety of international and domestic actors to use massive testing as a more effective tool to measure the extension of this particular pandemic were ignored by the public officials in charge of the response (IGHS, 2021). The decision to use the system to project an epidemiological curve based on the data it produced and to reject the application of testing led to the initial and erroneous assertion by the government that the pandemic would be over by May 2020. Mexico would become one of the countries with the lowest number of tests performed per population in the world (IGHS, 2021; OECD, 2021).

The government organised daily press conferences to inform the public on the development of the pandemic, but rather than assuring transparency, they became politicised spaces where the Undersecretary for Health Promotion and Prevention constantly sought quarrels with actors who did not agree with his management of the crisis. He and other public officials usually employed an overtechnical language that impeded the clear communication of the pandemic and the government's actions to the public.

Ensuring Sufficient Monetary Resources in the System and Flexibility to Reallocate and Inject Extra Funds

The social insurance layers of the public healthcare system, namely, IMSS and ISSSTE, are funded by tripartite contributions by employees, employers, and the state. Until 2019, the layer for people with no social insurance, that is, SPS, was funded by contributions from insured families and individuals and earmarked contributions by the federal and state governments, including earmarked funds for catastrophic health expenses and tertiary medical care.

Public health spending levels peaked during the second decade of the present century due to the expansion of coverage through the SPS. In 2013, public spending reached 3.1% of GDP and 53.8% of total health spending, while in per capita terms, it peaked at US\$565 in 2016. The growing trend

was reversed in the second half of the decade; by 2019, the year before the pandemic, public spending represented 2.7% of GDP, 49.3% of total spending, and US\$558 per capita (OECD, 2022). The reasons for these decreasing trends may be found in the fragmented healthcare architecture, which, after an initial boost to public spending due to the expansion of voluntary health insurance, obstructed the further aggregation of political preferences for a better supply of public services, along with the large role performed by the private sector, which reaches diverse population groups, including low-income families who can afford primary care in private doctors' offices, many times adjacent to pharmacies (Bernales-Baksai and Velázquez Leyer, 2021; González Block *et al.*, 2018).

The large role performed by the private sector reveals a strong dependence on market provision to meet healthcare needs in the country. Even if covered by a public scheme, many people choose or are forced to use private services because of the low quality of and limited access to public services. In fact, of the total number of people who reported frequent use of private services in 2013, 46% were covered by a public scheme, a proportion that increased to 60% in 2017 (INSP, 2021). Private services are mostly funded through out-of-pocket spending; in 2019, it represented 42% of total health spending (WHO, 2021).

The scarcity and precariousness of monetary resources did not improve in 2020. An increase in public spending to 3.1% of GDP is explained by the downfall in economic output caused by the pandemic, and while the government was able to inject additional funds into the system, they were mostly taken from the catastrophic health expenses fund that existed under the SPS, which the government appropriated since the new scheme for people without social insurance, INSABI, only covered primary and secondary care.

Universal Health Coverage

The public healthcare system has never reached the entire population. Public provision has consisted of different social insurance programmes for specific categories of labour market insiders, that is, formal sector employees and their families, and additional layers for people without social insurance coverage. By 2017, 82% of the population were insured by a public scheme, an expansion that represents a significant improvement compared to only 40% who were insured in 2000 but still left one-fifth of the population uncovered (INEGI, 2017). Moreover, that figure masks the process of implicit commodification that unfolds as many people, even if publicly insured, choose or are forced to seek treatment in the private sector due to deficiencies in the supply of public services (Bernales-Baksai and Velázquez Leyer, 2021). Hence, before the pandemic began, the country was still far from achieving universal health coverage, measured not only by the percentage of people who may have legal coverage but also by outputs and outcomes related to real access and generous and equitable provision of public services provided to the majority of the population (Martínez Franzoni and Sánchez Ancochea, 2016).

Instead of signalling progress towards universal coverage, the recent healthcare reform of 2020 represents a regression. The fragmentation and inequalities of the public system were reproduced and exacerbated since INSABI only replaced Popular Health Insurance. There was no attempt at unifying all public schemes. Tertiary care, which represents the main cause of catastrophic medical expenses that are unaffordable in the private sector for the majority of the population, was effectively excluded. No significant additional resources necessary to expand provision have been allocated in real terms, such that the healthcare budget for 2021 did not increase in relation to the 2020 budget, which considering the increase in demand due to the pandemic is also a step backwards. No plan for improving the quality and expanding social insurance services has been announced. Additionally, an attempt at reforming the medicines procurement system triggered serious supply disruptions and has only generated shortages across the country, especially of drugs needed to treat expensive diseases like various types of cancer (Reich, 2020).

The implicit commodification of healthcare intensified during the pandemic. Although the government expanded facilities for COVID-19 patients, the overwhelming demands left many patients suffering from other illnesses unprotected. Because of these unmet demands and the deficiencies of public schemes, especially the newly created INSABI, 56% of people who required medical care were treated in the private sector in 2020, and 45% and 57% of IMSS and ISSSTE beneficiaries preferred or were pushed to use private services. Among people who had COVID-19, only 14% were treated in public hospitals or clinics.⁶ Only 29% of people take into consideration entitlement to a public scheme when deciding where to seek care; the rest consider other variables related to quality and access (INSP, 2021). These indicators reveal the challenges that the country still has to overcome in order to even get near an authentic type of universal healthcare provision.

Appropriate Level and Distribution of Human and Physical Resources

The levels of human resources have improved during the present century. The number of doctors per 1,000 population passed from 1.6 in 2000 to 2.4 in 2019 (OECD, 2021), and from that total, the proportion of doctors employed in the public sector increased from 59% in 2000 to 71% in 2016 (González Block *et al.*, 2018). During the same period, the number of nurses increased from 2.2 to 2.9 per 1,000 population (OECD, 2022), of which more than 90% are employed in the public sector (González Block *et al.*, 2018). These changes are explained by the expansion of public healthcare provision through the SPS (González Block, 2020). Nonetheless, despite improvements, these levels of human resources were still below OECD averages, which registered 3.3 doctors and 8.9 nurses per 1,000 people in 2018 (OECD, 2022).⁷

The improvements in levels of human resources have not been matched by those of physical resources. During the current century, the number of

hospitals has only grown 0.3% (González Block *et al.*, 2020), while the number of hospital beds per 1,000 population decreased from 1.05 in 2000 to 0.97 (OECD, 2022). Of the total number of beds, 76% correspond to public hospitals (González Block *et al.*, 2020). Deep geographical inequalities are observed across the country in both human and physical resources. Poor and rural regions register a much lower supply. The uneven distribution of public and private resources reinforces health inequalities. For example, the rate of medical specialists per 1,000 people drops from more than 4 in the wealthy state of Nuevo León to 0.4 in the poorest state of Chiapas, while the number of public hospital beds per 100,000 people ranges from 177 in Mexico City to 43 in Chiapas (González Block, 2020).

Hospital capacity was expanded to face the pandemic. The federal government has argued that due to this measure, no COVID-19 patient was left untreated. Some degree of success can be claimed in that regard; however, three important points must be considered. First, many COVID-19 patients were sent back to their homes to avoid the saturation of hospitals, creating a high percentage of COVID-19-related deaths occurring at home, more than 50% of the total according to some estimates after the first year of the pandemic. Second, the differences in the quality of the supply of private and public services were made evident in the much lower mortality rates registered in the former than in the latter. Finally, the focus on COVID-19 left untreated many patients who suffered from other diseases, fuelling the high excess mortality rate of the country (IGHS, 2021).

Motivated and Well-Supported Workforce

Evidence exists of growing support for the healthcare workforce in recent years. The number of physicians that graduated from university increased by 2.3% annually between 2003 and 2017; the rate of specialists that were graduating as a proportion of the total population was higher than the OECD average. Nursing became a popular undergraduate programme, with an annual enrolment growth of 18.2% in the last decade. Lastly, the wage earnings of health workers are higher in the public sector than in the private sector (González Block *et al.*, 2018).

Diagnosed problems include the relative neglect of primary care and health promotion and prevention in training curricula and the lack of explicit and transparent standards for professionals in both the public and private sectors (González Block *et al.*, 2018). During the pandemic, medical personnel across the country protested insufficient levels of workforce support, including a lack of training and personal protective equipment (PPE). Constant reports were presented in the media of the inadequate supply of training and equipment provided by the federal government. One year after the pandemic began, 329 public demonstrations of this sort were reported. The neglect of the required support resulted in Mexico becoming the country with the highest mortality rate in the world among health workers in 2020, according

to Amnesty International. The Pan-American Health Organization (PAHO) reported in February 2021 that, out of 17 countries in the Americas, Mexican health workers accounted for 45% of COVID-19 deaths among health-care personnel (Agren, 2020, IGHS, 2021).

The Comparison of Strategies in Ecuador and Mexico

This comparison of the strategies adopted by the Ecuadorean and Mexican governments to prepare against health emergencies reveals similar weaknesses. Some improvements were achieved during the present century, but they were insufficient to build up the necessary resilience to face a health shock like the COVID-19 pandemic. As can be observed in Table 6.3, the existing institutional architecture was not effectively or efficiently activated

Table 6.3 Health shock preparedness in Ecuador and Mexico

<i>Strategy</i>	<i>Ecuador</i>	<i>Mexico</i>
Effective and participatory leadership	Delayed responses and a lack of effective leadership from the central government	Politicisation and centralisation of leadership by a reduced number of federal officials
Coordination of activities across government and key stakeholders	Lack of coordination with subnational governments and nongovernmental actors; late adoption of technical norms	Lack of coordination with subnational governments and nongovernmental actors
Effective information systems and flows	Deficient information flows and discretionary risk assessment at the local level	Deficient information flows due to a refusal to adopt massive testing
Ensuring sufficient monetary resources in the system and flexibility to reallocate and inject extra funds	Insufficient monetary resources and no flexibility due to external financial pressures and vulnerabilities to the business cycle	Insufficient availability of public monetary resources and high dependence on private spending
Comprehensive health coverage	A fragmented public system with reduced coverage levels and occupational and regional segregation	A fragmented public system with reduced coverage levels and an intensification of implicit commodification processes
Appropriate levels and distribution of human and physical resources	Unequal distribution of human and physical resources and unbalanced share of resources within territories	Unequal distribution of human and physical resources
Motivated and well-supported workforce	Limited support and further cuts in health personnel	Limited support provided to fight the pandemic

Source: Authors' own elaboration

to assure strong leadership and close and timely coordination between relevant political and social actors, while fragmented Bismarckian healthcare systems left large sectors of the populations unprotected and dependent on private provision, and the limited and unequal distribution of physical and human resources hampered the capacity to respond to the crises.

However, important differences can also be observed in the design and implementation of several strategies that stem from the particular domestic political economy arrangements of each case and their relation with global policy, as illustrated in Figure 6.1. In Ecuador, resilience was hampered by the challenges of keeping a resource-based economy afloat. COVID-19 has exposed the financial weaknesses of export-oriented and debt-dependent economies (Büscher *et al.*, 2021). Ecuador's President Lenin Moreno even referred to this period as “the real first world war” (*Financial Times*, 2020d). Despite efforts to put finances on a strong footing, the oil-dependent Ecuadorian economy was hamstrung financially. It grapples with US\$58.4 billion of total debt, more than half its annual gross domestic product (*Financial Times*, 2020b). With energy prices at a historical minimum and damage to the country's two main oil pipelines (*Financial Times*, 2020d), as a dollarised economy, the only influence it has over the money supply is preventing outflows.

Ecuador's ability to make policy decisions has been limited primarily due to strict global governance rules. These rules have made it difficult to sustain investments in the healthcare sector, retain and expand skills and

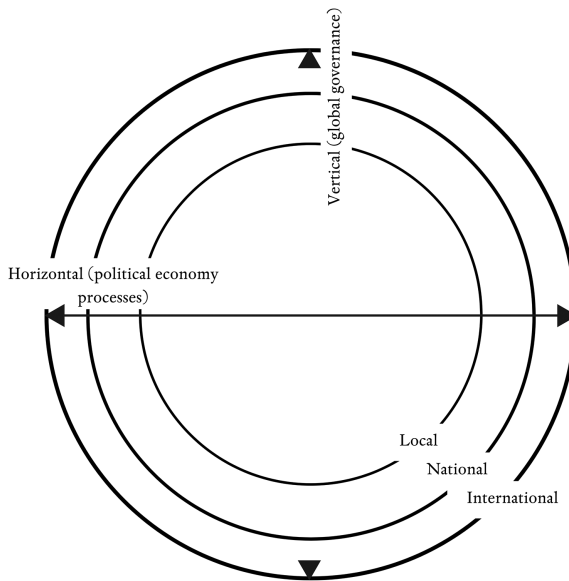


Figure 6.1 Global governance and horizontal political economy loops

capabilities within the public sector, and coordinate with private actors to tackle emergencies. The country's response to the COVID-19 pandemic was also hampered by financial constraints and international trade challenges, which resulted in delayed responses from the public sector during the crisis and its aftermath. While emergency cash transfers were provided as part of the social protection response, the country struggled to respond with agility and effectiveness. However, local variations did show promise in managing the crisis at a smaller scale, depending on effective leadership and participation, as well as cumulative investments in municipal capacities. The case of Ecuador highlights the significance of pandemic politics in the international political economy. The global governance of public health has led to significant health inequalities, both locally and globally, due to power disparities in access to healthcare. Dysfunctions in global health governance contribute to this unequal status quo.

In Mexico, the causes of the weak response can be found in the convergence created by the introduction of a failed health reform at virtually the same moment when the pandemic struck, as well as the existence of a federal government incapable and reluctant to develop social and policy learning processes essential to formulate an effective response to any crisis (Dunlop and Radaelli, 2018). Incremental improvements to healthcare provision since the early 2000s were abruptly undermined by the government that took office in late 2018, while despite the official rhetoric, historical deficiencies and inequalities not only were not reduced but were exacerbated. Rather than making progress towards the creation of a unified, effective, and efficient public healthcare system, its previous historical fragmentation was reproduced with the mere substitution of the voluntary health insurance programme for labour market outsiders, with a programme that intended to adopt universal principles by offering access as a citizenship right but that in practice represented a case of welfare retrenchment. The supply of tertiary care for informal sector workers and their families was eliminated, policy rules that established access and care for that population group were cancelled without publishing new rules, and the medicines procurement system for the entire public sector was dismantled without creating a new system that could meet demand.

The centralisation and politicisation of the management of the pandemic in Mexico shielded domestic policy from the influence of global policies emitted by the WHO, PAHO, and other international organisations. The government's inability to incorporate new knowledge that was emerging from international actors and organisations as the pandemic unfolded into its own response had grave consequences for the Mexican people. Populist polarisation can lead governments to act dogmatically, refusing dialogue with any social or political actor not aligned with their own decisions and preferences. International actors are commonly viewed with suspicion, as they tend to be considered representatives of foreign interests. However, when adopting this perspective, governments only end up damaging their populations, denying

them the formulation and implementation of policy solutions necessary to address their social problems.

Conclusion

The analysis presented in this chapter shows the blurred lines between government and governance in contemporary policymaking. Current problems that threaten the well-being of societies have causes and consequences that transcend national spheres. The assumption that domestic government actors have the capacity to solve them on their own without collaborations with foreign actors is simply an illusion. The collaboration between national and international state and non-state actors is necessary to formulate and implement the public policies necessary to protect people from the risks posed by global shocks like the COVID-19 pandemic. Transnational governance structures should have the capacity to endow global policy with the potential to influence national policy for the benefit of the people.

The comparative analysis of Ecuador and Mexico reveals the contradictions and limitations of global policies concerning pandemic politics. In the economic realm, foreign actors can impose a policy course on a national government, as observed in Ecuador, where the IMF urged for public spending cuts during economic difficulties. However, in the health and social realms, international organisations can only potentially influence domestic policymaking spaces through deliberation and learning processes. When confronted with a populist government, as in Mexico, the possibility of developing those processes is likely to fail. This demonstrates the procedural and instrumental aspects of pandemic responses, where global policies must generate a better balance and coordination between economic and social policy, as well as a more energetic intervention in the latter. Unless this is done, it is difficult to envision how national healthcare systems could be strengthened to face health crises like the COVID-19 pandemic. It is worth highlighting how governance and governmental actors have often failed to address pandemic politics, with dire human consequences. The comparative case studies of Ecuador and Mexico illustrate how global policies have struggled to develop effective pandemic responses and how domestic political systems can impede international organisations' ability to influence policymaking in the health and social realms.

The chapter has discussed how, even if formal compliance with international regulations was reported prior to the pandemic, the response in both cases was hampered by the symbolic nature of the decisions taken by political actors—who did not seem to abandon their preoccupation with avoiding political losses during the health crises—the failure or absence of adequate disease diplomacy—as in the case of Ecuador, where pressures from the global financial sphere contradicted the ability to meet policy recommendations from the global health sphere—the effects of medical populism—of which the Mexican response can even represent a model case—and the

political economy of health systems, with deep inequalities in the supply and access to health services by different socio-economic groups in both countries. Global economic policy seems to have the coercive capacity to shape national policy. Existing governance arrangements give international organisations the power to condition financial support for the adoption of economic reforms that limit the dynamic capabilities of the public sector to manage a crisis. Though reforms are justified to stabilise national finances, there is an apparent absence of coordination between financial and social policy organisations, like the ones governing global healthcare, that, especially in times of crises, yields devastating consequences, as happened in Ecuador during the pandemic. At the same time, the health crisis revealed the ineffectiveness of global policy in steering national decision-making processes, when the adoption of emergency measures devised with the knowledge generated by transnational actors is fundamental to protecting people's well-being. In fact, and as noted by Mazzucato and Kattel (2020), the global rules that govern sectors such as health since the early 2000s have made punitive use of intellectual property that limits the capacity to respond during deep crises. Global crises like the pandemic, as well as others that can be foreseen in the near future, require a much better coordinated and more effective global policy.

Notes

- 1 The previous version of the IHR dated back to 1969 and was restricted to activities related to the prevention and treatment of only cholera, plague, and yellow fever (Rodier *et al.*, 2007).
- 2 The use of private services is also incentivised by the deductions from income tax of private health spending, including private insurance and out-of-pocket spending.
- 3 The central role assumed by the UHPP was enhanced when other offices of the SS were eliminated or fused, part of the austerity plan adopted by the federal government when it took office in late 2018. For example, the previously autonomous regulatory agency for health treatments and medicines was put under the authority of the UPPS. The centralisation of functions created problems for the management of public healthcare provision on several fronts, not only in response to the pandemic (IGHS, 2021).
- 4 The acquisition of COVID-19 vaccines has been one area in which the leadership was not assigned to the UHPP but the Secretariat for Foreign Relations. It is not clear why that decision was made, but in any case, that could well be the only area where the government's response can be classified as successful since the number of vaccines from different companies has been plentiful (IGHS, 2021).
- 5 The interventions covered were pregnancies, births, and puerperium; caesarean deliveries; diseases of the appendix; complicated hernias; complicated gastric and duodenal ulcers; endoscopies; and cholecystectomies. In some states, specific agreements were signed for the provision of some private services to COVID-19 patients, like in Mexico City, but they were not extended to the entire country (SS, 2020).
- 6 Of the total number of people who reported to have had at least one symptom, 58% sought medical care and 43% received it in the private sector (INSP, 2021).

- 7 González Block et al. (2020) estimate a rate of 1.9 doctors per 1,000 population in Mexico based on national employment surveys, lower than the rate reported by the OECD.

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