

POLITICAL PARTIES AND POLICY REFORM: EXPANSION OF HEALTHCARE IN
LATIN AMERICA

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ABSTRACT

Zoila Ponce de Leon: Political Parties and Policy Reform: Expansion of Healthcare in Latin America

(Under the direction of Evelyne Huber)

Over the last decades, Latin American countries have attempted to expand access to healthcare and reform a system that discriminates based on the socioeconomic status of their citizens. Although previous research has posed that programmatic parties are important for policy quality, it has not shown the mechanisms through which programmatic parties can affect policy. Existing literature has also focused on the responsibility of strong left-wing parties for the expansion of social benefits, overlooking the development of reforms under right-wing governments. This study compares three processes of healthcare reform: the Chilean AUGE (Universal Access with Explicit Guarantees), enacted in the context of programmatic parties and a left-wing coalition in power, the Mexican Seguro Popular, approved in the context of programmatic parties and a right-wing party in power, and the Peruvian AUS (Universal Health Insurance), adopted in the context of non-programmatic parties and a right-wing party in power.

I argue that the programmatic commitments of parties, only present when the core values that unite party leaders relate to a policy issue, affect the quality of legislation. Reforms can follow a *partisan path* in which parties with values closely tied to the policy issue shape a reform's specifications regarding implementation and funding. Reforms can also follow a *non-partisan path* in which parties disengaged from the definition of specifications allow technocrats without partisan ties to dominate the policymaking process. Given the lack of commitment from

the main political actors, this leads to a policy that is poorly designed for effective implementation. Both paths can lead to reforms that increase formal coverage and even funding of the health sector. The key difference is in the feasibility of ensuring effective access to healthcare and the sustainability of funding. This study is based on 12 months of extensive field research in Chile, Mexico, and Peru, during which I conducted over 150 in-depth interviews with political elites, technocrats, and leaders of interest groups, accessed archives from the Legislatures and the Executives, and collected quantitative measures of the implementation of the reforms.

To my parents.

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TABLE OF CONTENTS

LIST OF TABLES	xii
LIST OF FIGURES	xiii
LIST OF ABBREVIATIONS.....	xiv
CHAPTER 1: INTRODUCTION.....	1
Theoretical Relevance.....	3
Plan of the Study	7
CHAPTER 2: THEORY AND RESEARCH DESIGN.....	11
Programmatic Commitment and Policymaking.....	15
Research Design.....	21
CHAPTER 3: THE PARTISAN PATH TO HEALTHCARE REFORM: POLICY REFORM AND PROGRAMMATIC COMMITMENTS IN CHILE.....	29
Before AUGE.....	30
Agenda-Setting	33
Debate	37
The right and the Solidarity Fund	41
Funding and gradualism.....	46
Programmatic commitment and AUGE.....	48
Implementation	51
Conclusion	57

CHAPTER 4: POLICY REFORM AND THE LACK OF PROGRAMMATIC COMMITMENT IN MEXICO	60
Before Seguro Popular	61
Agenda-Setting	64
Debate	68
PRI and the Treasury	70
PRD and the opposition to the role of the private sector	72
Infrastructure and resources	74
Implementation	76
Conclusion	82
CHAPTER 5: POLICY REFORM AND THE LACK OF PROGRAMMATIC COMMITMENT IN PERU	85
Before AUS	87
Agenda-Setting	89
Debate	95
Implementation	101
Conclusion	109
CHAPTER 6: TWO PATHS TO REFORM: POLITICAL PARTIES AND TECHNOCRATS IN LATIN AMERICAN HEALTHCARE POLICY	113
Agenda-setting	114
Debate	118
Implementation	127
Alternative Explanations	135
Conclusion	137
CHAPTER 7: CONCLUSION	139

Generalizability and Issues for Further Research	145
APPENDIX A: LIST OF INTERVIEWS.....	148
REFERENCES	157

LIST OF TABLES

Table 2.1. Theory and Hypotheses	19
Table 2.2. Case Selection.....	23
Table 3.1. Political Parties' Positions on a state-led versus market-led economy in Chile	33
Table 3.2. Funding for the Healthcare Reform in Chile	52
Table 4.1. Funding for the Healthcare Reform in Mexico.....	77
Table 5.1. Political Parties' Positions on a state-led versus market-led economy in Peru	89
Table 5.2. Formal Public Insurance Coverage and Public Budget in Peru.....	103
Table 5.3. Infrastructure in the Public Health Sector in Peru	105
Table 6.1. Formal Coverage: Percent (%) of Population with Insurance	127

LIST OF FIGURES

Figure 5.1. Main Actors and Connections of the Policymaking Process of AUS in Peru.....	92
Figure 5.2. Timeline of the Policymaking Process of AUS in Peru	111
Figure 6.1. Coherence: Parties' Positions on a State-led (1) versus Market-led (5) Economy ..	115
Figure 6.2. Funding for Health Reform: Public Health Expenditure (% of GDP)	128
Figure 6.3. Funding for Health Reform: Public Health Expenditure Per Capita (USD)	129

LIST OF ABBREVIATIONS

ACP	Private Clinics Association of Peru (Asociación de Clínicas Particulares del Perú)
APRA	American Popular Revolutionary Alliance - Peruvian Aprista Party (Alianza Popular Revolucionaria Americana – Partido Aprista Peruano)
ASE	State Solidarity Contribution (Aportación Solidaria Estatal)
ASF	Federal Solidarity Contribution (Aportación Solidaria Federal)
AUGE	Universal Access with Explicit Guarantees (Acceso Universal con Garantías Explícitas)
AUS	Universal Health Insurance (Aseguramiento Universal en Salud)
CEO	Chief Executive Officer
CNPSS	National Commission for Social Protection in Health (Comisión Nacional de Protección Social en Salud)
CONFUSAM	National Confederation of Municipal Health Officials (Confederación Nacional de Funcionarios de Salud Municipal)
CPOs	Causal process observations
CS	Social Contribution (Cuota Social)
CTIN	National Implementing Technical Committee (Comité Técnico Implementador Nacional)
EPS	Health Provider Entity (Entidad Prestadora de Salud) - Network of private providers
EsSalud	Peruvian Health Social Insurance (Seguro Social de Salud del Perú)
FMU	Universal Joint Fund (Fondo Mancomunado Universal)
FONASA	National Health Fund (Fondo Nacional de Salud)
Funsalud	Mexican Foundation for Health (Fundación Mexicana para la Salud)
GDF	Government of Mexico City (Gobierno de Ciudad de México)
HC	Health Committee (Comisión de Salud)
HSRP	Health Sector Reform Project

IFIs	International financial institutions
IMSS	Mexican Social Security Institute (Instituto Mexicano del Seguro Social)
Isapres	Private Insurance Institutions (Instituciones de Salud Previsional)
ISSSTE	Institute for Social Security and Services for State Workers (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado)
LyD	Libertad y Desarrollo
MEF	Ministry of Economy and Finance (Ministerio de Economía y Finanzas)
MINSAL	Ministry of Health of Chile (Ministerio de Salud)
MINSAL	Ministry of Health of Chile (Ministerio de Salud)
PAHO	Pan American Health Organization
PAN	National Action Party (Partido Acción Nacional), Mexico
PDC	Christian Democratic Party (Partido Demócrata Cristiano), Chile
PPC	Christian Popular Party (Partido Popular Cristiano), Peru
PEAS	Essential Plan for Health Insurance (Plan Esencial de Aseguramiento en Salud)
PELA	Parliamentary Elites in Latin America
PHR <i>plus</i>	Partners for Health Reform <i>plus</i>
PNP	Peruvian Nationalist Party (Partido Nacionalista Peruano)
PPD	Party for Democracy (Partido por la Democracia), Chile
PR	Proportional representation
PRAES	Promoting Alliances and Strategies
PRD	Party of the Democratic Revolution (Partido de la Revolución Democrática), Mexico
PRI	Institutional Revolutionary Party (Partido Revolucionario Institucional), Mexico
PRSD	Social Democrat Radical Party (Partido Radical Socialdemócrata), Chile

PS	Socialist Party of Chile (Partido Socialista de Chile)
PSMMG	Free Medical Services and Medicine Program (Programa de Acceso a Servicios Médicos y Medicamentos Gratuitos)
REPSS	State Regime of Social Protection in Health (Régimen de Protección Social en Salud)
RN	National Renewal (Renovación Nacional), Chile
SEG	Free School Insurance (Seguro Escolar Gratuito)
SERMENA	National Health Service for Employees (Servicio Médico Nacional de Empleados)
SF	Solidarity Fund (Fondo Solidario)
SIS	Comprehensive Health Insurance (Seguro Integral de Salud)
SMD	Single Member District
SMI	Maternity and Child Insurance (Seguro Materno Infantil)
SNS	National Health Service (Servicio Nacional de Salud)
SP	Seguro Popular (Popular Insurance)
SUNASA	National Health Superintendency (Superintendencia Nacional de Salud), 2009-2013
SUSALUD	National Health Superintendency (Superintendencia Nacional de Salud), 2014-present
TAHRP	Technical Assistance and Hospital rehabilitation
UDI	Independent Democratic Union (Unión Demócrata Independiente), Chile
UN	United Nations
UN	National Unity (Unidad Nacional), Peru
UPP	Union for Peru (Unión por el Perú)
USAID	United States Agency for International Development
VAT	Value Added tax
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Reforms seeking to expand access to social benefits promise to alleviate social inequality. Yet, the political process behind the formation of these reforms can severely affect the prospects for tackling these disparities. The implementation of neoliberal policies in Latin American countries in the 1980s and early 1990s left the region sharing a common challenge: increasing social disparity in access to healthcare (Ewig 2010). Over the last decades, several Latin American countries have attempted to expand access to healthcare and thus ameliorate a system that discriminates based on the socioeconomic status of their citizens (Garay 2016, McGuire 2010, Pribble 2013). The quality of these reforms, however, has varied, in terms of the expansion of benefits to people as well as the sustainability of such process.

Access to healthcare is one of the fundamental social rights for citizens in a democracy and is found to be a key determinant of development. The inefficient provision of healthcare and precarious health conditions remain crucial areas demanding action in Latin America. Although many governments in the region put this policy issue on their agendas, not all of them fully committed to a reform. The absence of political commitment to a reform seeking to expand access to healthcare can severely hinder its success. Understanding the circumstances under which actors such as political parties and technocrats help the development of reform that succeeds in expanding access to healthcare can inform the decisions of policymakers in their paths to reform.

There is evidence that the presence of programmatic parties (Stein & Tommasi 2007) as well as party system institutionalization (Scartascini et al. 2009) can help explain the success of policy reform. Nevertheless, the process behind *how* programmatic parties affect policymaking has received very little attention. Programmatic parties have core values that unite their leaders and drive the party program (Kitschelt 2000). Whereas certain policy issues are directly related to the core values of a party, others are not. The present study contends that having programmatic parties is not sufficient to explain the participation and impact that parties have on policymaking. Instead, what determines this participation and impact is whether a specific policy issue relates to the core values of parties and thus generates a programmatic commitment to the policy in question. The programmatic commitments of parties affect the quality of legislation and its implementation. If the parties participate in shaping key specifications of a reform regarding implementation and funding during debate, this forges a commitment of these same actors to the implementation of the reform, which determines its feasibility and sustainability.

The present study compares three processes of reform aiming to expand access to healthcare services, which were enacted in the 2000s in Latin America. The Chilean AUGE (Universal Access with Explicit Guarantees) was enacted in the context of programmatic parties and a left-wing coalition in power, whereas the Mexican Seguro Popular was approved in the context of programmatic parties and a right-wing party in power, and the Peruvian AUS (Universal Health Insurance) was adopted in the context of non-programmatic parties and a right-wing party in power. This small-n comparative analysis seeks to address the broader theoretical question of how programmatic versus non-programmatic parties affect the policymaking process of reforms.

A clarification of how programmatic parties affect policymaking is imperative. Based on the literature that finds programmatic parties to be an important predictor of policy quality, we

would expect a successful healthcare reform in Mexico, where two of their three main political parties are programmatic parties (Kitschelt et al. 2010, Magaloni 2006). However, if the core values uniting the leaders of the party, which make the party programmatic, do not relate to the policy issue at stake, the party will neither care to shape the specifications of the reform nor commit to its implementation. This was the case of PAN, a party that had Catholicism as the main core value uniting the party (Hawkins et al. 2010, Magaloni & Moreno 2003).

Multiple studies have focused on the role of strong left-wing political parties to understand the emergence of reforms seeking to expand social benefits (Huber & Stephens 2010, Pribble & Huber 2013). As Martínez Franzoni and Sánchez-Ancochea (2016) point out, although left-wing parties are not enough to explain the success of such reforms, they are an important part of the explanation. This body of literature has neglected a focus on countries where, instead, right-wing parties have supported and implemented reforms seeking to expand access to healthcare, as was the case in Mexico and Peru.¹

Theoretical Relevance

A key feature that defines healthcare in Latin America is inequality: between those citizens who use the public health sector's services and those who can afford private services, and also between citizens with formal jobs who have access to a healthcare scheme through salary contributions and those within the informal economy (over 50% of the Latin American population)² who are usually unprotected. Over the last decades, Latin America has witnessed major attempts to tackle these disparities. Reforms seeking expansion of healthcare access took

¹Important exceptions are Ewig 2016 and Garay 2016, which analyze efforts to expand social benefits led by right-wing parties.

²53.1% in Latin America and the Caribbean in 2016 (ILO 2018).

place in different countries such as Argentina, Brazil, Chile, Colombia, Ecuador, Mexico, Venezuela, Peru, and Uruguay.

As Martínez Franzoni and Sánchez-Ancochea (2016) discuss, many of these policies, labeled as “universal”, have become popular among both international organizations such as the World Health Organization (WHO) and the United Nations (UN) and national governments in the region that introduced them. As the authors point out, these governments call their policies “universal” because they “seek to reach everyone, even if they entail unequal benefits” (p. 6). These reforms, however, have been different: some more expansive than others, with more or less planning behind them, some more sustainable than others. *What explains the difference in quality of healthcare reform?*

An important body of literature has focused on the role of left-wing political parties, arguing that strong left-wing parties are responsible for the effective expansion of social benefits (Esping-Andersen 1990, Huber & Stephens 2001, Murillo 2005, Pribble & Huber 2013). Scholars find the ideology of parties to be pertinent to the allocation of attention towards certain issues and thus for public spending, expecting left-wing parties to be more inclined to pay attention to and spend on the development of the welfare state than right-wing parties (Blais et al. 1996, Castles 1982, Huber & Stephens 2012). In Latin America, we can generally position parties along the left-right ideological spectrum based on their views on the need for state intervention to generate equality and social inclusion (Levitsky & Roberts 2011). Based on this body of research, we should expect the development of healthcare reform in countries such as Uruguay and Chile, but be surprised by the same phenomenon in countries like Peru and Mexico.

Another factor that scholars find to be determinant of social policy reform is economic development, as wealthier countries have more funds available for social expenditure (Segura-

Ubiergo 2007). However, countries with the same level of economic development choose different types of social policies, both in high-income (Esping-Andersen 1990, Huber & Stephens 2001) and low-income countries (Filgueira 2007, Huber & Stephens 2010). In Latin America, episodes of social policy expansion have occurred both in times of economic growth and of economic crisis (Garay 2016).

Literature on democratization asserts that democracy is beneficial to the expansion of social protection (Przeworski 2000, Sen 1999). By opening a channel to demands from different groups, especially those being excluded from the provision of benefits, democracies respond to the needs of their citizens through pressure (Haggard & Kaufman 2008, Filgueira 2007, McGuire 2010). Along these lines, Garay (2016) finds that the presence of electoral competition and social mobilization can explain the expansion of social policy in the region. Specifically, such as in the case of Mexico, competition from a left-wing party may push conservative parties to undertake reforms. However, we need to understand what role the ruling party, PAN, and other actors had in the process of reform. Garay (2016) also asserts that in Peru neither electoral competition nor social mobilization was present. How can we then explain the development of reform attempting to expand access to healthcare in Peru?

Diffusion theory expects policy innovations to spread across countries (or local units), as foreign models captivate policymakers, based on political self-interest and using inferential shortcuts (Weyland 2006) or based on ideological commitments (Sugiyama 2013). By the 2000s, key international actors such as the World Bank, the WHO and the Pan American Health Organization (PAHO) were advocating for an expansion of healthcare and raised the awareness of governments of the need for such reforms. However, as Weyland (2006) points out, since there is rarely a singular model of healthcare reform, diffusion in this area does not take place in

the form of policymakers just borrowing blueprints. As shown by Ewig (2010), a network of international actors can be more successful at influencing policy when it involves the national bureaucracies, since these “epistemic communities” will count with bureaucratic commitment. These external models, however, do not necessarily generate political commitment.

A significant group of quantitative studies has explored the relationship between the quality of policy and the participation of policymakers, pointing out the importance of party system institutionalization in different regions of the world (Scartascini et al. 2009), as well as programmatic parties in Latin America (Stein & Tommasi 2007). These studies do not differentiate between policy areas; neither do they look into the process that can explain *how* programmatic parties affect policymaking. Why do programmatic parties have a positive impact on the quality of reforms? What are the consequences of reform adopted by non-programmatic parties? These are broader theoretical questions that the present study seeks to answer.

The analysis developed in the following chapters shows that reforms seeking to expand access to healthcare can follow a *partisan path*, in which parties with core values closely tied to the policy issue play a central role in defining key policy specifications regarding funding and implementation. Reforms can also follow a *non-partisan path*, in which parties without core values or with values that do not relate to the policy issue are disengaged from the definition of specifications and allow technocrats to dominate the process. Given the lack of political commitment, this leads to legislation that is poorly designed for effective implementation. Although both paths may lead to reforms that increase formal coverage and even increased funding for the health sector in the short-term, the feasibility of ensuring access to healthcare is hindered when funding is unstable and infrastructure falls short.

The findings of this study contribute to the literature on social policy reforms by pointing out *how* the presence (or lack) of programmatic commitment affects policymaking and final policy. Furthermore, expanding the study of healthcare reforms to cases in which non-programmatic parties carried out reforms can allow us to better understand the role of important actors such as technocrats and the private sector. The degree of autonomy of technocrats in the health sector in many Latin American countries has changed across time. While technocrats enjoyed a great degree of autonomy during the 1990s, it decreased in the early 2000s since international financial institutions (IFIs) started to lose interest in healthcare reform (Dargent 2014, Ewig 2010). However, during the policymaking process for the reforms in Mexico and Peru, technocrats without partisan ties enjoyed a great degree of autonomy, which allowed them to dominate the policymaking process. How can we explain such phenomena?

Multiple studies have shown that programmatic parties are highly relevant for democracy and representation (Levitsky & Cameron 2003, Mainwaring 2018, Mainwaring & Scully 1995) and have suggested that they can also be important for policymaking, without further exploring this last connection. The present study contributes to this body of literature by showing under what circumstances programmatic parties affect policymaking and final policy. More broadly, the present research project demonstrates the need to bridge the literature on social policy and the literature on political parties, as well as the relevance of careful analysis that disentangles the mechanisms through which political parties affect policy.

Plan of the Study

The rest of the study is organized as follows. Chapter 2 presents the theoretical framework and the research design of the study. It provides the expectations for agenda-setting, debate, and implementation based on whether the core values of the political parties involved in the process

of reform relate to the policy issue at stake. It then describes the logic of the case selection employed in this study, operationalization of dependent and independent variables, and the process tracing approach used to collect evidence.

Chapter 3 examines the policymaking process of AUGE in Chile, enacted in 2004. Chile is one of the few Latin American countries where political parties were considered strongly programmatic (Kitschelt et al. 2010). The chapter begins by briefly describing the healthcare context in Chile before the reform, in which the country, like most in the region, struggled with a fragmented system and the lack of access to required treatment (long waiting lists) and quality services in the public sector. Promoted and implemented by the left-wing governing coalition Concertación, the reform sought to increase access to healthcare by gradually expanding coverage for more health conditions and guaranteeing access to quality treatment for a set of diseases. The chapter is divided into agenda-setting, debate, and implementation, demonstrating how the programmatic commitments of the Chilean parties, both left- and right-wing, led to the approval of a bill that included the necessary specifications and funding to be implemented. This chapter also shows that the participation of the parties in the definition of specifications forged a commitment of these same actors to the reform's implementation, which determined its feasibility and sustainability.

The argument that the participation and impact of programmatic parties on the policymaking process of reforms depends on whether the core values of the parties are related to the policy issue under debate is further supported in Chapter 4. The analysis of the Seguro Popular reform in Mexico, approved in 2003, shows how the presence of core values uniting the leaders of the right-wing PAN was not enough for the development of a programmatic commitment to Seguro Popular. The absence of connection between the policy issue and the party's core values led to a

lack of commitment to the reform. The chapter starts with a brief explanation of the state of the healthcare sector in Mexico before the reform, to then continue to provide evidence for the impact of the lack of programmatic commitment on the reform at the different stages of the policymaking process.

Chapter 5 examines the case of the AUS reform in Peru. The context of the reform approved in Peru in 2009 during the right-wing APRA's government deviates from similar attempts to expand access to healthcare. Left-wing parties in Peru were extremely weak during the policymaking process of AUS and the political parties were non-programmatic. Beginning with a brief depiction of the healthcare system in Peru before the reform, the chapter proceeds to demonstrate how parties that lacked core values uniting their leaders and had no commitment to the reform did not care for the definition of its specifications regarding funding and implementation. In that context, technocrats dominated the process of policy formation at every stage of the process, from agenda-setting to implementation, which accompanied by the lack of commitment from the main political actors, led to poorly specified policy and deficient implementation.

Chapter 6 presents a comparative analysis of the process of reform in Chile, Mexico, and Peru. The chapter demonstrates that reforms seeking to expand access to healthcare can follow a *partisan path*, in which parties whose core values are related to the policy issue hold a programmatic commitment to defining the specifications of the reform. In the absence of political parties interested in the prospect of reform, technocrats can dominate the policymaking process, in a *non-partisan path* to reform. When parties are disengaged from the definition of policy specifications and have no political commitment to it, this path can lead to poorly designed legislation and deficient implementation. One of the most important distinctions

between the two paths to reform is the feasibility of ensuring access to healthcare and the sustainability of funding that the partisan path grants. Towards the end, this chapter briefly discusses the shortcomings of alternative explanations to help us understand the variation in policy quality across the three cases under analysis.

Chapter 7 concludes by summarizing the main findings of this study and providing a discussion of the significance of the main theoretical implications of this study.

CHAPTER 2: THEORY AND RESEARCH DESIGN

In the late 1990s, most Latin American countries shared two key features of their healthcare systems: fragmentation and inequality. Their healthcare systems were divided into a public and a private sector, with the first being segmented into a social security system and a system for those outside the formal economy. This situation meant that different segments of the population had access to different healthcare benefits, with some enjoying broad protection schemes whereas others had no protection at all (Ewig 2010). Many governments in the region have attempted healthcare reforms with the main goal of alleviating these disparities.

Policies that seek to expand access to healthcare for their populations have been labeled “universal” by national governments and international organizations since their aim is to “reach everyone, even if they entail unequal benefits” for different segments of the population (Martínez Franzoni & Sánchez-Ancochea 2016: 6). Recent reforms have varied considerably in terms of the expansion of access to healthcare and sustainability over time. In other words, the quality of the reforms has varied.

One of the most prominent areas of study that seeks to explain variation in social policy focuses on economic factors, finding that the wealth of a country is an important predictor of policy reform since it guarantees the necessary funds for it (Segura-Ubiergo 2007). Nevertheless, as the seminal studies of Esping-Andersen (1990) and Huber & Stephens (2001) show, the level of economic development of countries cannot predict the type of social policy undertaken by different high-income nations. The same applies to low-income countries, where measures of

economic growth do not determine how expansive or sustainable social policy is (Filgueira 2007, Huber & Stephens 2010). Along those lines, Latin America has witnessed episodes of social policy expansion both in times of economic growth and of economic crisis (Garay 2016).

A focus on how political factors shape social policy expansion has found democracy to be favorable for the development of policy aiming to expand social benefits (Przeworski 2000, Sen 1999). Democracies foster the organization of citizens' demands and guarantees channels through which these demands can reach the political domain. In that context, the segments of the population being excluded from the provision of benefits can pressure their governments to devise policy measures that includes them (Haggard & Kaufman 2008, Filgueira 2007, McGuire 2010). In Latin America, Garay (2016) finds that electoral competition and social mobilization can both trigger the expansion of social benefits. The author asserts, however, that only social mobilization guarantees a broad scope of coverage. For instance, competition from a left-wing party pushed conservative parties to undertake reforms, as was the case for healthcare and pensions in Mexico, but in the absence of social mobilization, restrictive policy was developed. This incisive analysis leaves out an analysis of the actors that pushed for reform and how this participation shaped the legislation and its implementation. Moreover, Garay (2016) asserts that in Peru neither electoral competition nor social mobilization was present. Yet, the Peruvian government enacted a healthcare reform that attempted to expand access to healthcare.

An important body of literature has focused on the diffusion of policy models to explain the emergence and type of reform, finding that policy reforms can travel from one country to another (and across local units). These foreign models can captivate policymakers in search of political rewards, who rather than devising completely new solutions, use inferential shortcuts to attach a solution to the problem of incomplete access to benefits (Weyland 2006). Sugiyama (2013) finds

that not only policymakers' self-interest can drive the adoption of policy innovations but also their ideological commitments. Although by the late 1990s, IFIs started to lose interest in healthcare policy (Dargent 2014, Ewig 2010), the World Bank, as well as the WHO and the PAHO were advocating for an expansion of healthcare to excluded segments of the population, thus raising the awareness of governments to the need for change. As Weyland (2006) asserts, given that a singular model of healthcare reform is extremely rare, diffusion in this area does not arise in the form of policymakers borrowing models.

The success of international networks at influencing policy can be greatly benefited by the involvement of national bureaucracies, as Ewig's (2010) analysis of the effects of the first and second waves of neoliberalism on the development of health policy in Peru shows. The participation of national bureaucrats in what the author calls "epistemic communities" guarantees bureaucratic commitment to the new models. However, these external models can still lack political commitment, which can be determinant for the implementation of reform and ultimately for its success.

Scholars also find that the role of strong left-wing parties for the expansion of social benefits is crucial to understand the variation in the quality of reforms (Esping-Andersen 1990, Huber & Stephens 2001, Murillo 2005, Pribble & Huber 2013). Since the ideological position of a party can predict how they allocate attention towards different policy issues and therefore how assign public funding for them, we expect left-wing parties to be more inclined to pay attention to and direct funding towards the development of the welfare state than right-wing parties (Blais et al. 1996, Castles 1982, Huber & Stephens 2012). In Latin America, we can generally position parties along the left-right ideological spectrum based on their views on the need for state intervention to generate equality and social inclusion (Levitsky & Roberts 2011). Although

reforms seeking to expand access to healthcare in the region have been prominent in countries traditionally characterized by the presence of strong left-wing parties in government, such as Uruguay and Chile, reforms have also taken place under the rule of right-wing parties, as has been the case in Mexico, Peru and Colombia.

A focus on the responsibility of left-wing parties for social policy reform neglects cases where right-wing parties presided and carried out such reforms. Moreover, this approach risks overlooking other features of parties, apart from ideology, that can influence the policymaking process, as well as disregarding the role of other actors such as technocrats and private insurance and private providers. The exploration of other party features in relation to policymaking has been limited. An important exception is Pribble's (2013) work on the development of social policy reform in South America. The author shows how the internal organization of left and center-left parties can determine how universal a policy is. Depending on how strong the ties between elites and the base are within the party ("electoral-professional" vs. "constituency-coordinating"), policy might move further towards universalism. In the case of right and center-right parties, which act as opposition to the policy initiatives studied by the author, the ties between the elites and business determines the extent to which the interests of this group will be reflected in the bills. How do we understand the role of the right when they presided and carried out reforms seeking to expand access to healthcare and what can we expect from these reforms?

In Latin America, we have seen the disappearance of many programmatic political parties and the development of weakly and non-programmatic ones (Kitschelt et al. 2010, Levitsky 2001, Levitsky et al. 2016, Mainwaring 2018, Mainwaring and Zoco 2007). By the early 2000s, Chile and Uruguay were the only remaining countries that had strongly programmatic political parties, whereas parties in Bolivia, Colombia, and Peru qualified as weakly programmatic

(Kitschelt et al. 2010). Surprisingly, with the exception of Pribble (2013), this phenomenon has been overlooked in terms of policymaking.

Although the importance of features such as party system institutionalization and how programmatic parties are for democracy and representation has been deeply studied (Aldrich 1995, Levitsky & Cameron 2003, Mainwaring 2018, Mainwaring & Scully 1995), their impact on the policymaking process has been underexplored. Some studies have pointed out the importance of party system institutionalization (Scartascini et al. 2009), as well as programmatic parties in Latin America (Stein & Tommasi 2007) for the quality of policy reform. Using large N quantitative analysis, these studies do not look at the process that can explain *when* and *how* programmatic parties affect policymaking. Based on this literature, we would not expect to find healthcare reform in Peru, a country with parties characterized by the use of charismatic and clientelistic linkages rather than policy programs (Cameron 2011, Kitschelt et al. 2010, Levitsky 2013, Levitsky 2018, Levitsky & Cameron 2003, Tanaka 2005); whereas we might expect successful reform in Mexico where they have programmatic parties and a degree of party system institutionalization (Kitschelt et al. 2010, Magaloni 2006). *How are reforms adopted in the context of non-programmatic parties? What are the consequences of reform adopted by non-programmatic parties?* These are questions that remain unanswered.

Programmatic Commitment and Policymaking

Programmatic parties are organized around a coherent set of policy alternatives and appeal to citizens on the basis of policy programs (Kitschelt 2000, Kitschelt et al. 2010, Roberts 2002).

Programmatic parties have a vision of how society should be organized, an analysis of what the most pressing problems in a society are as well as a plan to solve them and thus get closer to an ideal. We can distinguish two components in the programmatic nature of parties: (1)

programmatic unity of its core members and (2) programmatic appeals to voters. When studying parties as policymaking actors, it is the first component that deserves further evaluation.³

A party *is* programmatic when it has core values that unite its leaders and drive the party program. These core values are the values that parties care about the most and therefore unite parties organically. Whereas certain policy issues are directly related to the core values of a party, others are not. I argue that *being* programmatic is not sufficient to explain the participation and impact of parties in the policymaking of healthcare reforms, but what determines this participation and impact is whether a specific policy relates to the core values of parties and thus generates a ***programmatic commitment*** to the policy in question. A party can hold core values regarding key issues such as a state-run versus market-led economy or a Catholic versus secular state, but only if a specific policy relates to such values will the party have programmatic commitment to the policy at stake. If a policy lacks connection to the core values of the party, there will be no commitment to that policy, neither to the definition of its specifications or its implementation. In this sense, *being* programmatic does not equate to having a programmatic commitment to every policy issue.

In the case of a policy proposal that looks to expand healthcare access, if the values of equality and social inclusion are a core value of a party, since this value is related to the expansion of healthcare, the party will hold a programmatic commitment to shaping the policy in alignment with such values: promoting reforms with a broad scope of coverage. If a free market is a core value of the party, the party will hold a programmatic commitment to shaping the policy in alignment with this core value: promoting minimal state intervention in the health system and the participation of the private sector. Instead, if Catholicism is a core value of the party, since a

³Regarding the second component, recent research has shown that parties can use different types of linkage to different constituencies at the same time (Luna 2014).

proposal looking to expand access to healthcare does not affect this value, the party will not hold a programmatic commitment to shaping the policy specifications. We must think of the programmatic nature of parties in a more differentiated manner, by policy issue, instead of simply whether a party is either always programmatic or not.

Then, how do we explain healthcare reform in cases where parties' core values do not directly relate to this policy issue? How do we explain reform in the context of parties without core values, which have no commitment to the policy? Actors outside the government, such as think tanks, international organizations, organized interests, or individual technocrats from these groups will play a key role in these cases. Therefore, we can expect to have reforms following a *partisan path*, in which parties with core values closely tied to the policy issue play a central role in defining the specifications of the reform. Reforms can also follow a *non-partisan path*, in which parties disengaged from the definition of its specifications allow outside actors to dominate the policymaking process. Both paths can lead to reforms that expand coverage and even increased funding for the health sector. The key difference is in the quality of reform: the feasibility of ensuring access to healthcare and the sustainability of funding.

The key dependent variable I seek to explain is the quality of reform enacted and implemented. By tracing the policymaking process of healthcare reforms across agenda-setting, debate and implementation, I identify 1) the main actors placing the issue into the agenda, 2) the policy specifications regarding funding and implementation that are shaped during debate, and 3) the feasibility and sustainability of ensuring access to healthcare during implementation. Thus, my research shifts the focus away from social spending patterns (Kaufman & Segura-Ubiergo 2001, Segura-Ubiergo 2007) and towards the process behind the formation of policy and how it determines the quality of legislation and implementation.

Programmatic commitments shape key specifications of a reform regarding implementation and funding. Furthermore, the programmatic participation of political parties in the definition of specifications forges a commitment of these same actors to implementing the reform, which determines its feasibility and sustainability. When parties lack core values or such values do not relate to the policy, legislation may still pass, but technocrats without partisan ties dominate the process. Given the lack of commitment from the main political actors, this leads to a policy that is poorly designed for effective implementation.

The policymaking process can be laid out in different stages: agenda-setting, debate, and implementation (Jones & Baumgartner 2005, Kingdon 2010). During the agenda-setting stage, recognition of a problem occurs as a “policy window” opens for those issues that have succeeded in gaining attention from politicians. Then, the participants inside and outside the government debate the different policy proposals. Finally, after a policy choice is made, implementation follows. The presence or absence of parties’ programmatic commitments to a policy affects the process of policymaking at its different stages.

During **agenda-setting**, the presence or absence of parties’ programmatic commitments determines whether political parties or actors outside the government place a policy issue into the political agenda and lead this process. If a policy issue relates to the core values of a party, the party will introduce the issue to the agenda. If the issue does not relate to the core values of any of the parties or if parties lack core values uniting their members, a policy issue lacks connection to the parties. In this context, actors outside the government (i.e. think tanks, international organizations, organized interests, or individual technocrats from these groups) will place the issue into the political agenda.

If a policy is not related to the core values of the party, the programmatic commitment is absent. In that context, other factors will determine the support or opposition of the members of the party. For instance, they might support a policy due to the command of the party leader or for the new resources that it entails, or oppose it because it could harm their ability to enforce patronage. Table 1 shows the impact of the presence of programmatic commitments on the quality of healthcare legislation by tracing the effect across the three main policymaking stages.

Table 2.1. Theory and Hypotheses

		Does Party Have Core Values?	
		Yes: Programmatic Parties	No: Non-Programmatic Parties
Does Party Have a Programmatic Commitment to Policy?	Yes: Core Values Related to Policy	Agenda-setting Parties introduce issue to the agenda.	
		Debate Parties shape policy specifications: 1) funding for reform’s implementation and 2) infrastructure assessment. High quality legislation	
		Implementation Specifications determine feasibility and sustainability of ensuring access.	
	No: Core Values Unrelated to Policy	Agenda-setting Actors outside the government introduce issue to the agenda (think tanks, technocrats).	
		Debate Parties do not shape policy specifications: 1) funding and 2) infrastructure assessment. Low quality legislation	
		Implementation Lack of specifications hinders implementation due to instability of funding and shortage of infrastructure.	

During the process of **debate**, the programmatic commitments of parties are highly relevant as they determine the specifications of the bill regarding implementation and funding. When the reform proposal is directly related to the core values of a party, the party attempts to shape the proposal according to its programmatic commitments. On the contrary, if the issue is only tangential to such core values, the party does not attempt to shape key specifications of the bill.⁴ Instead, they leave the process in the hands of individual technocrats. In the context of parties that have no core values, technocrats without partisan commitments are allowed a lot of freedom to introduce poorly specified bills, which politicians will not care to shape, thus generating poor quality legislation. Further, the participation of the different political parties, shaping the different specifications of the bill, helps to generate a commitment to the reform before its implementation. When they do not participate in the process of debate, and in deciding key specifications of the reform, there is no political commitment to the reform before its implementation.

Technocratic actors can also play an active role in the context of programmatic parties, but they are likely to have partisan ties. In contrast, in the context of non-programmatic parties, technocrats lack partisan ties and hence long-term incentives to specify policy proposals. These actors lack commitment to the policymaking process given the short-term nature of their influence. Not every technocrat-led policymaking process leads to poorly specified bills, but in the context of parties that lack political commitment to the policy and technocrats without partisan ties, we see a widespread lack of commitment.

Finally, during **implementation**, the specifications of the bill shaped during the process of debate determine the feasibility of ensuring access to healthcare as well as the sustainability of

⁴They may want to influence more detailed provisions such as, for instance, the possible access to contraception in the case of healthcare reform.

the project in the long-term. An analysis of the infrastructure gap that the government needs to cover beforehand allows for a smooth implementation of a reform seeking to expand access to healthcare. On the other hand, when these specifications are absent, shortage of infrastructure and unstable funding can get in the way of the actual expansion of effective access to healthcare. In this context, relevant actors in charge of the implementation, such as local authorities, can end up hindering the reform process. The main repercussion of the lack of programmatic discussion and lack of political commitment to the reform is a poorly executed implementation.

The case studies and comparative analysis that follow in the next chapters will support my theoretical argument as well as demonstrate the shortcomings of alternative explanations.

Research Design

In order to test my theory about how the relation between a specific policy and the core values of parties affects the policy approved and its implementation, I use a small-n comparative analysis of the policymaking process of three healthcare reforms. These reforms, enacted in the 2000s in Latin America, aimed to expand access to healthcare services: Universal Access with Explicit Guarantees (**AUGE**) in Chile, Seguro Popular (**SP**) in Mexico, and Universal Health Insurance (**AUS**) in Peru. My case selection primarily concentrates on seeking variation across the political parties that presided the reforms in each country in terms of how programmatic they were. Chile is one of the few Latin American cases where parties are considered strongly programmatic, whereas all major parties in Peru qualify as weakly programmatic (Kitschelt et al. 2010). The case of Mexico has more variation since two of its three main parties are considered programmatic.

In Chile, AUGE passed a vote in Congress in 2004. The center-left Concertación coalition, formed by the Party for Democracy (PPD), the Socialist Party (PS), the Christian Democratic

Party (PDC), and the Social Democrat Radical Party (PRSD), introduced the reform proposal. In opposition, they had the right-wing coalition Alianza, formed by the Independent Democratic Union (UDI) and National Renewal (RN). These parties relied on programmatic linkages to gain support from their electorate and on party programs to unite the party leaders (Pribble 2013, Kitschelt et al. 2010). The Chilean parties not only were programmatic and thus had core values uniting their leaders, but the healthcare reform was related to the core values of the parties and therefore they had a programmatic commitment to the policy.

In Mexico, the party in government, the right-wing National Action Party (PAN), presided Seguro Popular; the Institutional Revolutionary Party (PRI) and the Party of the Democratic Revolution (PRD) were the main forces in opposition. The reform was approved in 2003. Political parties in Mexico are varied, with PAN and PRD relying on policy programs more than PRI, which has been categorized as a patronage machine (Kitschelt et al. 2010, Langston 2017, Magaloni 2006). Although PAN was a programmatic party, the core value uniting the party, Catholicism, did not relate to the healthcare reform, PRI had no core values uniting its leaders and only a sector of PRD held core values related to the policy issue. Therefore, the Mexican parties had no commitment to the reform.

The Peruvian Congress approved AUS in 2009. Although the party in power, the Peruvian Aprista Party (APRA), had originated as a left-wing party in the 1920s, it shifted towards the right in the subsequent decades. As part of the opposition, there was the left-wing coalition between Union for Peru (UPP) and the Peruvian Nationalist Party (PNP), as well as the right-wing National Unity (UN).⁵ The weak and electorally volatile Peruvian party system has been characterized by the use of charismatic and clientelistic appeals (Cameron 2011, Kitschelt et al.

⁵The UPP-PNP coalition was formed to support the presidential candidacy of Ollanta Humala in 2006, who lost the election to García but went on to become president in 2011. UN formed before the 2001 presidential elections and presented Lourdes Flores as its candidate.

2010, Levitsky 2013, Levitsky 2018, Levitsky & Cameron 2003, Tanaka 2005). The Peruvian parties lacked core values uniting their leaders and hence they had no programmatic commitment to the reform. Table 2 shows the logic of this case selection.

Table 2.2. Case Selection

		Does Party Have Core Values?	
		Yes: Programmatic Parties	No: Non-Programmatic Parties
Does Party Have a Programmatic Commitment to Policy?	Yes: Core Values Related to Policy	Chile Government: Concertación (PS, PPD, PDC) Opposition: Alianza (RN, UDI)	
	No: Core Values Unrelated to Policy	Mexico Government: PAN Opposition: PRD (divided)	Peru Government: APRA Opposition: UPP-PNP, UN

Political parties' positions on a key issue such as whether an economy should be regulated by the state or the market can show the level of agreement present among party leaders and thus be indicative of the presence of core values within the parties. I compared data collected by the Parliamentary Elites in Latin America (PELA) study, a series of surveys conducted with all

Members of Parliament in each country (Alcántara 2012).⁶ These surveys are conducted once per legislative cycle in different Latin American countries. Thus, I used data from the 2002-2006 cycle in Chile, which was collected in 2002, from the 2000-2003 cycle in Mexico, collected in 2001, and the 2006-2011 cycle in Peru, collected in 2006.

The case election also allows for variation in terms of the ideological orientation of the political parties that participated in the policymaking processes of the reforms. The Mexican and Peruvian healthcare reforms were presided and implemented by right-leaning parties, whereas it was a left-wing coalition that pushed for and initially implemented the reform in Chile. Whereas there has been a heavy focus in the literature on reforms seeking to expand social benefits led by left-wing parties (Esping-Andersen 1990, Huber & Stephens 2001, Murillo 2005, Pribble & Huber 2013), this phenomenon has received little attention when presided and implemented by right-wing parties. We must understand what explains 1) the emergence of reforms in these cases and 2) the quality of reforms approved and implemented. If right-wing parties are presiding attempts to expand healthcare access, regardless of whether these attempts are successful or not, it is important to understand how and why.

Many of these policies seeking to expand access to healthcare, have been labeled as “universal” by both international organizations such as the World Health Organization (WHO) and the United Nations (UN) and national governments in Latin America (Martínez Franzoni & Sánchez-Ancochea 2016) since these policies “seek to reach everyone, even if they entail unequal benefits” (p. 6). These reforms, however, have been different: some more expansive than others, with more or less planning behind them, some more sustainable than others. The key dependent variable this study seeks to explain is the quality of the reforms enacted and implemented. For this purpose, I identify key policy specifications that policymakers (legislators

⁶Observatorio de Élités Parlamentarias de América Latina <http://americo.usal.es/oir/elites>

as well as members of the Executive) define during the process of debate in Congress, which are crucial for the implementation of the reform if approved.

I focus on 1) specifications regarding the sources of funding for the reform's implementation, and 2) specifications regarding the need for an infrastructure assessment to establish the gap that the government needs to cover before the reform's implementation. These two key policy specifications determine the feasibility of a reform seeking to expand access to healthcare. The presence of these specifications defines whether legislation is considered high or low quality. In this way, the present study shifts the focus away from social spending patterns and budgets (Brown & Hunter 1998, Huber et al. 2008, Kaufman & Segura-Ubiergo 2000, Rudra 2008, Segura-Ubiergo 2007) and towards the quality of the policy approved, thus addressing the importance of policymakers' engagement in crafting policy specifications and of political commitment for the sustainability of reforms.

I trace the policymaking process of the healthcare reforms in Chile, Mexico, and Peru across agenda-setting, debate, and implementation. If the type of political parties present in the country matters for the quality of the legislation and its implementation, we must observe the process of reform from the moment the proposal was placed into the political agenda, throughout debate, and finally assess how the debate had an impact on the implementation. Therefore, I first identify the main actors placing the issue into the agenda, in order to observe the participation that political parties have during this initial stage of the process. Then, I trace the definition of policy specifications shaped during debate as well as the actors responsible for them, which allows me to distinguish between a *partisan* versus *non-partisan path* to reform. Finally, I evaluate how the specifications regarding funding and infrastructure, that the process of debate arrived to, had an impact on the implementation of the reforms and their sustainability.

A small-n research design allowed for an in-depth analysis of three key cases of healthcare reform. Through process tracing, this analysis can help us assess the causal mechanisms in which explanatory factors affect the outcome under study, the quality of reform. Through a small-n comparative study, we can understand a political phenomenon that takes place in a larger set of cases sharing similar characteristics with the cases under study (Brady and Collier 2010). The “detailed examination” of each case enables the development and testing of political explanations that can be generalized to other cases (George & Bennett 2005: 5).

This exhaustive type of analysis produces qualitative data in the form causal process observations (CPOs), which are defined as “an insight or piece of data that provides information about context, process, or mechanism, and that contributes distinctive leverage in causal inference” (Brady and Collier 2004: 2).⁷ CPOs help to observe the operation of causal mechanisms and thus assess causal complexity (George & Bennett 2005). As Bennett (2010) explains, these observable implications are of great importance since they help the researcher establish causal direction among variables, uncover variables not previously considered and therefore lead to new explanations, as well as decide among alternative explanations. In this study, the collection of CPOs is utterly crucial to assess the role that the participation and commitment of parties has thought the policymaking process.

This study is based on 12 months of extensive field research in Santiago de Chile, Mexico City, and Lima. I conducted over 150 in-depth interviews with key actors from inside and outside the government, accessed archives from the Legislatures and the Executives, and collected statistics on the implementation of the three reforms. I included structured as well as open-ended types of questions in my questionnaires. Interviews with the actors that took the lead

⁷Mahoney (2010) provides an extensive discussion on the importance of CPOs for the development of causal inference.

in the promotion and design of the reforms, such as health ministers, legislators and party leaders, and technocrats from the Ministries of Health were crucial for the reconstruction of the policymaking processes. The reconstruction of these processes, however, would not be thorough enough without the interviews I conducted with ministers of finance, technocrats from the Ministries Finance, representatives of private insurance and private provider companies, representatives of international organizations in each country, and policy experts.

I triangulated the in-depth information collected through original interviews with transcriptions of all the debates on the reforms that took place in the committees and floors of the Parliaments, as well as proceedings and reports. I carefully read the congressional debates from Chile, Mexico and Peru, identifying the different actors participating in them as well as the arguments they used in support or against the proposals. I also accessed official documentation from meetings carried out in the Health and Finance Ministries. I supplemented the information gathered through interviews and government archives with data from secondary sources and from newspaper archives.⁸ This was important in order to establish general timelines for the reforms under study and to cross check the accuracy of accounts from interviewees.

I also collected yearly data assessing the implementation of the reforms: population coverage by the different insurance schemes (public and private), general budgets assigned to the reforms since the beginning of implementation, general health budgets, government health expenditure per capita, and funds assigned for the development of infrastructure and human resources.

⁸I conducted searches by keyword in the online archives of the main newspapers in each country, which allowed me to have access to every article mentioning the reforms under study, develop timelines of events, as well as to identify key actors.

The methodological approach of this study is crafted to answer the research questions of this project. In order to understand how reforms are adopted in the context of non-programmatic parties versus programmatic parties and what impact non-programmatic parties versus programmatic parties have on the reforms being adopted, the collection of process observations was crucial.

CHAPTER 3: THE PARTISAN PATH TO HEALTHCARE REFORM: POLICY REFORM AND PROGRAMMATIC COMMITMENTS IN CHILE

I trace the policymaking process of the Universal Access with Explicit Guarantees (*Acceso Universal con Garantías Explícitas*, AUGE) reform that was enacted in 2004 in Chile. The reform in Chile was promoted and implemented by a left-wing coalition. Chile is one of the few Latin American countries where parties are considered strongly programmatic (Kitschelt et al. 2010). The study of a case where programmatic commitment is present can shed light on *how* political parties committed to a reform influence the policymaking process and final policy outcomes.

The center-left Concertación coalition, formed by the Party for Democracy (PPD), the Socialist Party (PS), the Christian Democratic Party (PDC), and the Social Democrat Radical Party (PRSD), introduced the reform proposal. In opposition, they had the right-wing coalition Alianza, formed by the Independent Democratic Union (UDI) and National Renewal (RN). These parties relied on programmatic linkages to gain support from their electorate (Pribble 2013, Kitschelt et al. 2010). The healthcare reform was related to the core values of the Chilean political parties.

Social policy literature clearly explains why we should expect the development of healthcare reform in countries like Chile and Uruguay, where left-wing parties are strong (Esping-Andersen 1990, Huber & Stephens 2001, Murillo 2005, Pribble & Huber 2013). Moreover, more recent studies have shown that the internal organization of left and center-left parties as well as social

mobilization can determine how universal a policy will be (Garay 2016, Pribble 2013). In this chapter, I show *how* and *why* the presence of programmatic parties in Chile in the 2000s shaped the quality of the legislation enacted and had further repercussions on its implementation.

Before AUGE

The Chilean health system, developed in the 1950s, was quite efficient for its time. There were segmentation problems as there were two different subsystems: the National Health Service for Employees (*Servicio Médico Nacional de Empleados*, SERMENA) for white-collar workers and the National Health Service (*Servicio Nacional de Salud*, SNS) for blue-collar workers and poor people. Even so, the system brought access to the majority of the population. This system was responsible for very low rates (in regional comparison) of maternal and infant mortality as well as mortality due to infectious diseases. Augusto Pinochet's regime had a large negative impact on the state of the health sector in the country. The military regime created *Instituciones de Salud Previsional* (Isapres), which could offer alternative private insurance for workers, thus competing with the public sector. The lack of investment in infrastructure further weakened the public health system.

Since the return to democracy in 1990, the reform of the health sector has been a latent issue in Chile due to the fragmentation of the system and the lack of resources. President Aylwin's first speech to Congress in 1990 emphasized the precarious situation in which Pinochet's regime left the health sector: "*technological backwardness, insufficient human and financial resources and lack of renewal of the infrastructure have affected negatively the responsiveness of the public sector to the demands for attention.*" The first two Concertación governments focused on repairing the precarious system the dictatorship left. For instance, in his last speech to Congress

in 1999, President Frei pointed out that a third of all hospital infrastructures in Chile at that moment had been built during his administration.

In the early 2000s, Chile, as many countries in the region, had a fragmented health system with the National Health Fund (FONASA, created after the integration of SERMENA and SNS into a single system) covering those with formal jobs and the poor (70%), *Instituciones de Salud Previsional* (Isapres) offering alternative private insurance (21%), and a small segment of people without any type of insurance (9%). Although, in theory, FONASA covered the treatment of most health conditions, the lack of opportunity for access to required treatment (long waiting lists) and the quality of services were concurrent problems for its beneficiaries.

Several of my interviewees, who were part of the two previous Concertación governments, pointed out that although Aylwin and Frei invested heavily in the health sector, a reform that would bring more equity to the system was not prioritized. Instead, the democratic consolidation of the country as well as macroeconomic stability was a top priority. Also, some Concertación members mentioned that there was a lack of agreement within the coalition regarding the type of healthcare reform that should be carried out: whereas some members thought the reform should achieve a system with the public sector in charge of both insurance and provision (and therefore Isapres should disappear), others proposed a system where the collaboration between the public and private systems was possible. Neither side ever had enough support to generate a real debate regarding a reform.

An important precedent for AUGÉ was the first study of epidemiological transition in the country. A group of experts from two World Bank projects, Technical Assistance and Hospital rehabilitation (TAHRP) and the Health Sector Reform Project (HSRP), in collaboration with the Office of International Cooperation of the Chilean Health Department, produced this study in

1994.⁹ The study, which showed the change in health priorities in Chile, was highly relevant since the knowledge of the disease burden allowed the elaboration of a plan of prioritized diseases to tackle. The public speeches of the AUGE reformers, including president Lagos, as well as my interviews, show that the change of health indicators -typical of a developed society transitioning from the prevalence of infectious diseases to non-communicable diseases (such as cancer and diabetes) was a key factor that triggered the need for a reform and also shaped the type of reform they wanted to carry out.

The health reform introduced in the 2000s in Chile shared two main long-term goals with the Mexican and Peruvian reforms: 1) universal insurance coverage of the population, which was particularly important in the cases of Mexico and Peru, and 2) gradually increasing coverage of health conditions by guaranteeing access to treatment for a set of diseases, and hence level the benefits across schemes. In Chile, unlike in Mexico and Peru, political parties were closely involved at all stages of the process, as the reform connected with their core values. The positions of Members of Parliament representing the different parties, on whether an economy should be regulated by the state or the market are indicative of the parties' consensus on these values.

As table 1 shows, Chilean parties are quite cohesive on the role of the state, not just regarding the regulation of the economy but also in the provision of social benefits. Whereas the survey of members of parliament did not ask about social benefits, evidence from interviews with politicians suggests that they also cohere on the role of the state in providing social benefits (Pribble 2013).

⁹The only previous reference in the region was the study of Brazil in 1989. The next one would be Mexico in 1995.

Table 3.1. Political Parties' Positions on a state-led versus market-led economy in Chile

Political Parties	State (1)	2	3	4	Market (5)	Standard Deviation
PS	0	55.6	44.4	0	0	0.50
PPD	0	13.4	66.7	20	0	0.58
PDC	0	27.8	44.4	27.8	0	0.75
RN	0	0	12.5	56.2	31.2	0.64
UDI	0	0	0	44	56	0.50

Source: Parliamentary Elites in Latin America (PELA) 2002 study

Agenda-Setting

The Chilean reform was born through the programmatic commitments of the center-left coalition, Concertación. Although there was no agreement on the details of the reform, the parties discussed its necessity in order to bring more equity to the health system. The health reform was placed on the agenda in 1999, during the presidential campaign of Concertación's leader, Ricardo Lagos (PS). Concertación's manifesto made health reform a priority, pointing out the inequities of a system where financial resources determined access to health. As members of Concertación Enrique Accorsi (PPD, Deputy 2002-2014) and Soledad Barría (PS, Health Minister 2006-2008) noted, the inclusion of health reform as a priority in the program had been discussed with the different parties that formed the leftist coalition. However, there had been no discussion regarding the details of the reform. Lagos' 1999 government program *To Grow with Equity (Para Crecer con Igualdad)* made healthcare reform a priority, particularly pointing out the inequities of a system where the financial resources of citizens determined their access to health. The program established the goal of guaranteed health attention to all Chileans.

Despite agreement on the importance of the reform, process was not exempt from conflict. Concertación's leader, Lagos, gave the task of crafting the reform to Hernán Sandoval (PPD), even though he was not appointed health minister. Instead, Michelle Bachelet (PS) was appointed as head of the Health Department (MINSAL). Sandoval put together a first proposal and sent it to the newly appointed health minister in March 2000. Lagos' first speech to Congress in May 2000 emphasized that the reform would be a priority. That same month, the president established the Reform Commission, in charge of the proposal for the reform. The commission was formally chaired by Bachelet and had Sandoval as executive secretary.¹⁰ Below this ministerial committee, there was a small but important body of technocrats that represented the different governmental branches and had different partisan affiliations (PS, PPD and PDC).

Some members of Concertación did not agree with this two-headed organization and considered that Sandoval took decisions single-handedly, without consulting MINSAL. Most interviewees noted the problems that surfaced between Sandoval and Bachelet due to a conflict in the decision making process, and a difference in strategies for the reform. For the president and his commission, the strategy was to give patients rights and guarantees for the attention they received. As it was impossible to achieve such a goal for all health interventions, a prioritized set of interventions was needed. On the other hand, for Bachelet -and other members of Concertación- the focus of the reform had to be in strengthening the public sector, for which more financial resources were needed. They also opposed the idea of prioritization, as it would generate discrimination against those patients with non-AUGE diseases.

Bachelet did not publicly declare her opposition to AUGE, but sought to block it from behind the scenes. Sandoval noted that for Lagos and the commission it was clear that the

¹⁰The heads of the Treasury, the General Secretariat of the Presidency, and the Ministry of Labor also formed the commission.

problem of inequity in the system “*could not just be solved with more funding*” but it was necessary “*to grant rights and access mechanisms to these rights.*” Several members of the Reform Commission I interviewed, including Sandoval, refer to the tense meetings they held with MINSAL representatives since they felt that they were trying to delay the development of the reform. Patricia Frenz recounts that when she joined the commission in 2001 “*it was said that the reform was dead, stuck.*” An ally of Bachelet was the Chilean Medical College that also opposed the idea of prioritization and rather supported giving more funding to the public sector.¹¹ There was a difference in strategies for the reform between Bachelet and the reform Commission, which led to a conflict known to all participants of the reform process. In this way, the different members of the coalition shared the same goal, to improve an unequal system, but they did not agree on the means to that end.

The commission organized the reform into 4 different parts: 1) the AUGE Law, that set a health plan including 4 different guarantees: access, opportunity, financial coverage and quality; 2) the Health Authority Law, which aimed to strengthen the regulatory role of the Health Department; 3) modifications to the Isapres Law (18.933) in order to increase the regulations imposed on them; and 4) the Financing Law that would establish the financial resources for the health reform. The first part included the creation of a new institution: the Health Superintendence (*Superintendencia de Salud*), to monitor both public and private health providers as well as insurers (FONASA and Isapres).

In January 2002, Sandoval, fed up with Bachelet’s obstruction, submitted his written resignation to Lagos, but the president did not accept it and decided to instead appoint a new

¹¹Bachelet organized working groups with the Medical College representatives in 2001, without any coordination with the commission. According to Sandoval, Bachelet and her team “*querían emborrachar la perdiz.*” [In English: “they wanted to get the partridge drunk”: a Chilean colloquialism that means that somebody is trying to cause distraction.]

health minister and name Bachelet as minister of defense. The new minister Osvaldo Artaza (PDC) had one command: to send AUGE to Parliament and achieve its approval. Following this, some members of the commission became part of MINSAL.¹² A collaborative work began between the Reform Commission and MINSAL.

MINSAL submitted the AUGE bill to Congress in May 2002. AUGE had the main goal of bringing more equity to the system, which would be achieved by giving patients rights and guarantees for a prioritized set of health interventions. The bill included the creation of the Health Superintendency, to monitor public and private health providers as well as insurers (FONASA and Isapres).¹³ In June, they sent the Financing Law bill, which would establish the financial resources for the reform. In July, the government sent the remaining two bills, part of the AUGE reform. During the agenda-setting process, parties in Chile were committed to the introduction of healthcare reform into the agenda.

AUGE was born through the programmatic commitments of a left-wing coalition and their leaders. The need for reform had been present since the return to democracy and the first Concertación government in 1990. Although there was no agreement as to what type of reform should be carried out, political parties such as PPD, PS and PDC discussed the necessity of a reform to bring more equity to the health system. Experts from the three parties were part of the Reform Commission.

Kaufman & Nelson (2004) argue that the trend in Latin America in the 1990s was that political parties and politicians did not matter; social policy reform was not important for them. They argue that the actors of healthcare reforms were: public health specialists (rather than top-level politicians, who had few incentives to sponsor a reform), the Ministry of Finance and other

¹²Antonio Infante was appointed Vice-Minister.

¹³The commission also introduced modifications to the Isapres Law (18.933) in order to increase the regulations imposed on them, and the Financing Law that would establish the financial resources for the health reform.

high-level economic officials, and international organizations. In the Chilean case, the main source of reform was a party coalition and its leaders, including a top-level politician, President Lagos, founder of PPD and leader of the Concertación coalition. According to Garay (2016), the reform in Chile was prompted by electoral competition. Although this sparked the inclusion of the reform into the agenda, it does not explain why political parties and their leaders, instead of outside bureaucrats like in Mexico and Peru, led the agenda-setting process.

Debate

The prospect of a healthcare reform that aimed to expand access to healthcare was directly related to the core values of the Chilean parties, and hence they were committed to defining the specifications of this policy. Whereas the center-left looked to move the health system closer to the goal of equity, the right sought to defend the interests of the private sector. A point of convergence, however, between left and right was their interest in a feasible process of implementation for AUGE. The role that parties had as policymakers during this process, behaving programmatically, can help us to understand AUGE in terms of its specifications regarding financing and infrastructure, which determined both the implementation and the sustainability of the reform in the long term. Even though there were differences within Concertación, there was a programmatic commitment of their members to the need of a reform that could bring equity and could be implemented.

Technocrats also participated in Chile, but they were not isolated from the platforms the Concertación government proposed. Most of them had partisan affiliations within Concertación, which meant they followed the programmatic guidelines of the coalition. The role technocrats have during policymaking depends on the type of parties present. If the parties hold a programmatic commitment to the reform, technocrats serve the purpose of developing specific

goals. If parties behave non-programmatically, technocrats dominate the process, which can lead to the introduction of poorly specified bills, and equally important, a lack of political commitment to implementation.

Concertación members agreed on a compromise to improve the functioning of the public sector in order to arrive (in the long-term) at a system where public insurance would prevail. FONASA was definitely underfunded, but the AUGE team thought that it would be hard to just ask for more money and instead decided to have a short to medium-term approach that involved working with the private sector in order to grant rights to people. AUGE included an article that stated that if the public system was not able to provide the guaranteed health interventions that people were entitled to, FONASA had the obligation of buying such interventions from private providers. A parallel strengthening of the public sector would take place, as well as imposing restrictions on the discrimination Isapres carried out against their affiliates. Concertación members pushed for a highly specified reform.

In the Chamber of Deputies, the Health Committee (HC) held 18 hearings between June and November of 2002. After intense discussion, AUGE reached floor debate in December of that year. Whereas support for a health reform was widespread within Concertación, there was not widespread support for the strategy that President Lagos had for the reform. Members of the so-called “medical block” in the Chamber, formed by Concertación members who were also doctors opposed some specifications of AUGE. A first point of disagreement was the inclusion of the private sector. For the block, this would only serve to strengthen the private sector. A second issue was the prioritization of diseases, which the medical block considered discriminatory against those patients with non-AUGE diseases. For then Deputy Accorsi, *“from PPD and PS, there was opposition to having AUGE pathologies because it would generate a huge waiting list*

of people [with] non AUGE [diseases].” Soledad Barriá (PS), who was at MINSAL during Bachelet’s term as health minister noted that “[the idea of granting] enforceable rights itself was good, but they could not stop to take care of what was not AUGE.” This split did not represent a programmatic division. Although there was division regarding the strategy of reform for the Chilean health system, there was programmatic agreement on the need for a reform that would increase access to health for people and bring more equity to the system.¹⁴

This schism within Concertación, however, was not particular to the healthcare reform. The distinction between the so-called “two souls” of Concertación: “self-flagellants” (*autoflagelantes*) and “self-satisfied” (*autocomplacientes*) dates back to its formation during the end of the dictatorship (Camargo 2007). Whereas the first criticized the coalition’s excessive attention to economic growth to the detriment of social development, the second argued that they did the best they could.¹⁵ These two sides have been present during the last two decades, showing Concertación’s internal disagreement regarding the market-oriented socioeconomic development model Chile has followed (Luna 2010). President Lagos and those around him have usually been considered “self-satisfied”, willing to collaborate with the private sector. The Medical Block has been part of the “self-flagellant” sector, which saw these reforms as yielding to the neoliberalism inherited from Pinochet’s dictatorship. This split between the “purist” side that felt AUGE was not going far enough and the more “pragmatic” AUGE reformers did not

¹⁴This was not a PS-PPD versus PDC division, but it cut across parties. Indeed, Senator Antonio Viera-Gallo (PS) and FONASA Director Alvaro Erazo (PS) supported AUGE, whereas Senator Mariano Ruiz-Esquivel (PDC) sided with the medical block. In the words of then Health Vice-Minister Antonio Infante, “Lagos’ strong presidential figure” was determinant in settling these differences.

¹⁵In 1998, the self-satisfied side published *Renovar la Concertación: la Fuerza de Nuestras Ideas*, and the self-flagellants, *La Gente Tiene Razón*. Also an important piece is Deputy Sergio Aguiló’s 2002 *Chile entre dos Derechas* 2002, as well as the 2007 *La Disyuntiva: una Concertación Conservadora o una Concertación al Servicio de la Mayoría*.

represent an ideological division. In the words of Camargo (2007: 21), it was “*a 'translation mechanism' of critical trends rather than a generator of political-ideological 'ruptures'.*”

The Chilean Medical College put up a strong battle to AUGE. They wanted the public to turn against AUGE and they carried out an aggressive public campaign against the reform. At the core of the public campaign the Medical College carried out against AUGE was the opposition to the prioritization of pathologies, with basically the same argument of the “medical block” in Congress. The doctors also argued that the clinical protocols that AUGE was going to introduce would cut their freedom of medical practice and force them to practice in specific ways.¹⁶ However, as many interviews state (including then president of the Medical College, Enrique Paris) the main reason for the doctors’ opposition was their fear of seeing their income reduced. It was mainly their private practice that was going to be affected with AUGE. First, those doctors working in private clinics would lose some of their patients since AUGE would establish a network of clinics and doctors to treat patients with AUGE pathologies. Second, doctors would lose an important source of income if the public sector were able to provide attention to all AUGE patients.¹⁷ Unlike with Bachelet during her term in MINSAL, the association had a very bad relationship with the department under Artaza. The minister started a strong public campaign to convince people about the benefits of AUGE, which was highly successful in gaining popular support.

¹⁶Another organization that joined the Medical College in its opposition to AUGE was the National Confederation of Municipal Health Officials (*Confederación Nacional de Funcionarios de Salud Municipal*, CONFUSAM). CONFUSAM’s President Esteban Maturana reaffirmed that AUGE “*forced the privatization of health*”.

¹⁷It was a common practice (and still is for non-AUGE pathologies) that if the public hospital could not provide the required attention, either because of long waiting lists or lack of technology, doctors would suggest the patients to go to their private offices. These offices could often be located right in front of the public hospitals.

The right and the Solidarity Fund

Concertación faced the opposition of the right-wing coalition *Alianza por Chile* and their reluctance to accept the Solidarity Fund (SF), a mechanism of redistribution across affiliates of the public and private sectors, which would take 3% of the 7% compulsory contribution workers made (to either FONASA or Isapres), and then give back to the affiliates adjusting for their risk based on sex and age.¹⁸ Alianza represented the position of the Isapres Association. Isapres made it clear that they strongly opposed the SF. The fund implied an estimated net transfer of around 15 billion Chilean pesos (22 million USD) from Isapres to FONASA (Blackburn et al. 2005). The association's Research Manager Gonzalo Simon noted that the fund "*caused panic among Isapres*" as they began to perform internal calculations of how the size of their market share would decrease. There was a close relationship between Isapres and the right-wing parties, through which the association provided information to Alianza senators. Simon recounted that congressman Alberto Espina (RN) "*came every week, for 2 hours, to understand the operation of the [health] system before the start of the discussion*".

Isapres Association's Executive Director Rafael Caviedes noted that they agreed with having health priorities. Then Research Manager Gonzalo Simon also noted, "*the coverage of Isapres affiliates was much higher than that provided by the public sector, therefore they had no problem with AUGE*." Caviedes and Simon participated in most hearings in the Health Committee in the Chamber of Deputies. In the hearings in which the deputies discussed the Solidarity Fund, they made their position against the fund clear. The private insurance sector was, indeed, at great risk. Their premiums would have gone up to compensate for the 3% taken

¹⁸Isapres charged a female affiliate more than 4 times what was charged to a male of the same age, even though the actual difference of spending was only 3 times. The price associated to risk applied to a 69 year or older man was nearly 20 times that of men between 2 and 18 years old, although on average the maximum difference in spending observed between them was only 14 times (Blackburn et al. 2005: 10).

through the SF. Therefore, their affiliates with fewer resources would have moved to FONASA. For both Caviedes and Simon the SF was like imposing a specific tax on those affiliated to a private insurance. According to them, people should not have to contribute to a system (public) that they would never use. For Simon, the solidarity of the health system was present through the general taxes that all Chileans pay “*since rich people are the ones paying more [taxes].*”

With a majority in the Chamber of Deputies, Concertación was able to pass AUGE on the floor in January 2003, even though Alianza legislators voted against the articles regarding the SF. The veto Alianza could impose during floor debate in the Senate was a latent threat. Several interviewees noted that Alianza made it clear that they would veto the reform on the floor and therefore the SF had to be removed from the bill. Evelyn Matthei (UDI), Alberto Espina (RN), Edgardo Boeninger (PDC), Mariano Ruiz-Esquide (PDC), and Antonio Viera-Gallo (PS) composed the Health Committee in the Senate. Boeninger and Viera-Gallo defended the SF, pointing out the “skimming” that Isapres had carried out since they were created, hence pushing people with higher risk to the public sector. Boeninger stressed that the fund had the goal of providing equity in the access to health. The arguments of Matthei and Espina against the SF ran along the same lines of Isapres’. The fund was an unfair mechanism for those affiliated to Isapres since there would be a transfer of part of their contributions to the public system, which they would never use. The right-wing senators argued that the money for AUGE should come from general taxes and not affiliates’ contributions. In personal interview, Matthei stated: “*I was not opposed to giving more money to the public sector, but it had to be through [general] taxes.*” The senators argued unconstitutionality and posed that they would go to the Constitutional Tribunal if the fund were approved.¹⁹

¹⁹Isapres sought to influence the policymaking process of AUGE through the right-wing political parties, as Luna & Rovira Kaltwasser (2014) call it, “the partisan way”. They also influenced the process through their own

In March 2003, President Lagos name Pedro García (PDC) as the new health minister.²⁰ During the final Health Committee hearing on AUGE, García stated: “*The Executive has great interest in the speedy dispatch of this bill and hopes that it has a highly favorable vote on the Senate floor*” and therefore the disagreement regarding the Solidarity Fund, “*motivates the Executive to withdraw it from the project.*” All members of the committee valued this decision - including Ruiz-Esquide (PDC), who was part of the more purist “self-flagellant” side of Concertación- on the grounds that the withdrawal of the fund from the bill made it possible to generate broad consensus. Moreover, as Ruiz-Esquide pointed out, the Treasury had made it clear that AUGE had enough funding to be implemented. In personal interview, then Health Minister García agreed and stated that the SF “*was only 16 billion pesos [around 30 million USD]; AUGE could have fallen because of it... It was marginal... Why get into a fight and risk losing it all?*”²¹ As then health policy advisor to the Treasury, Consuelo Espinosa, put it: “*We had to sacrifice the fund... otherwise the whole reform would have fallen.*”

The SF also represented a point of contention within Concertación. According to Boeninger (2005), a sector of PDC rejected the fund because the transfer of the contributions of Isapres’ affiliates would affect the middle class, a “*key core of their electoral support.*”²² In the words of former Health Minister Pedro García (PDC), “*there was the will to go forward with the fund, but*

organization, think tanks, and the media. Dávila (2005) details how the website of the association linked to numerous articles on the topic, as well as seminars they organized. As Pribble (2013) shows, the think tank Libertad y Desarrollo (LyD), linked to the right-wing party UDI, had an important participation, producing studies about the expropriation character of the fund as well as its unconstitutionality. Rodrigo Castro, one of the main researchers of LyD at that time indicated: “*we had always been the technical arm of UDI and RN since the return to democracy*”.

²⁰Artaza’s reputation was damaged since the General Controller’s Office had been investigating him for spending public money on mass communication campaigns to promote AUGE, and he had faced three doctors’ strikes.

²¹The government also asked the Health Committee to eliminate the articles regarding the Maternity Fund, another mechanism that the right opposed. During the first hearing of the committee, Health Minister Artaza stated: “*with the goal of generating broader political agreements, which can make the reform viable... the articles that referred to the Maternity Fund were eliminated.*”

²²Although Senator Boeninger (PDC) defended and voted in favor of the fund at the Health Committee, he actually disagreed with the idea (Dávila 2005).

there were many middle class people in Isapres... that was part of our electorate.” Not only PDC members were skeptical of the fund, however. Some members of PS and PPD preferred to remove that part of the bill if there were not enough guarantees that no public funds would flow towards Isapres’ affiliates. Soledad Barría (PS), advisor to deputy members of the Medical Block indicated that *“the price to pay was the transfer of resources to the private sector. We supported the fund if its resources were only for the public sector.”*

Whereas Isapres were very active in the discussion of AUGE, this was not the case of the private clinics. Then and current CEO of Clínicas de Chile, the private clinics association, Ana Alborno explained that they considered it appropriate to organize the system around those diseases that were more prevalent and to provide guarantees to the patients. However, that the same standards of quality had to be imposed on the private and public systems alike. She stated: *“it is not fair competition if the public system can deliver services with such a low level [of quality] ... If there are requirements for the private sector, it should be for everyone.”* Another issue that worried the private providers was the creation of networks, as this would benefit some of their clinics but harm others, depending on whether they were included in specific networks or not. The most important issue for the clinics was the possibility that FONASA would have to purchase services from them. The AUGE bill established that if the public provision system was not able to provide the guaranteed health interventions, FONASA had the obligation of buying such interventions from private providers. Alborno recalls that they thought they would have a massive demand from FONASA affiliates.

It is important to highlight the fact that vertical integration (the owners of insurance companies also own private clinics) is a very common practice in Chile. Isapres’ President Rafael Caviedes is a great defender of the purchase of private services. He stated: *“I understand*

health as a right, the role of the state to guarantee it... but not the state having to provide services.”

Finally, the AUGE bill returned to the floor in the Chamber of Deputies in August of 2004 to be discussed and voted on the amendments the Senate made. The deputies approved the set of amendments introduced by the Senate, as a whole, with 105 in favor, 1 vote against (Enrique Accorsi, PPD), and 1 abstention (Guido Giradi, PPD).²³ In personal interview, Accorsi recounted that “[President] Lagos imposed his position, he called one by one to each Member of Parliament... Lagos disciplined the congressmen.” Today, Accorsi does not regret his vote but he is also content that AUGE was approved because its implementation has been beneficial to Chileans. He states that, “*it was a tie between strengthening the public system and integrating with the private system.*”

The bill introducing modifications to the Isapres Law (one of the 4 parts of the AUGE reform) was approved in May 2005 and included an Inter-Isapres Compensatory Fund. This fund had the goal of correcting the discrimination against people with high risk (such as women and the elderly) but only among Isapres’ affiliates. According to former Treasury advisor Consuelo Espinosa, this new mechanism was part of the negotiation between the right-wing Senators and the Treasury that took place before the floor debate in the Senate. Espinosa stated that “*in order to convince the Reform Commission, they [the Treasury] told them that the Inter-Isapres Fund could be extended to the public system at some point.*” The leader of the Reform Commission, Hernán Sandoval agreed that the Inter-Isapres fund was part of the negotiation and that “*the idea [of the fund] was being introduced and, at some point, there could be a unified fund.*”

²³According to Pribble (2013), many legislators were convinced that, although equity enhancing, the fund was not an essential financial pillar of the reform.

This bill also specified the changes that the private system would have to go through in order to deliver the system of explicit guarantees (AUGE plan) to its beneficiaries. AUGE did eliminate the vulnerability of private sector members with regard to the 56 pathologies the plan included²⁴, for which affiliates would receive medical attention independently of their capacity to pay. For the first time since Pinochet's regime created Isapres, the government was able to impose on them the obligation to provide a minimum coverage to their affiliates.²⁵ Moreover, the law established limits to the co-payments affiliates would pay for AUGE diseases (in FONASA and Isapres).²⁶

Funding and gradualism

The funding of the health reform was an important part of the discussion. The Financing Law was enacted in August 2003. AUGE was to be funded through a 1% increase of VAT, increased efficiency in the use of health funds, government revenues, and a new universal premium (Blackburn et al. 2005).²⁷ The Reform Commission, in collaboration with MINSAL's Epidemiology Division, calculated the cost of the universal premium that would be taken from the current premiums of affiliates to the public and private sectors. Consuelo Espinosa, then at the commission emphasized that they needed to "*make [AUGE] more viable and sustainable over time.*" The Treasury is obliged to give resources to AUGE, based on this premium, which has made AUGE sustainable over time. The Treasury showed commitment to fund AUGE from

²⁴The AUGE bill did not specify which would be the 56 pathologies but rather the procedure to define them.

²⁵Before AUGE, Isapres administered the 7% contribution of their affiliates without any obligations of coverage.

²⁶Groups A (poor) and B (monthly income equal or lower than 210,000 pesos/38 USD) would have zero co-pay, the total value of their universal premiums was covered by FONASA.

²⁷The original draft of the bill proposed increases in taxes on tobacco, alcohol, diesel, gambling and an increase in VAT of 0.25%. The Treasury vetoed the raises in specific taxes, which was supported by the right-wing parties UDI and RN, as well as some DC members.

the beginning. Former Superintendent of Health Manuel Inostroza emphasized that AUGE specifications guaranteed resources, diminishing the power of the Treasury.

The AUGE law also required cost studies every time the set of AUGE pathologies was updated. The law established the set of prioritized pathologies to be evaluated every three years in order to progressively include more diseases that, according to epidemiological studies, were a priority to cover. This process was carried out in consultation with the scientific community, which collaborated in the development of the packages.

During the debate of AUGE, the opposition from the Medical College, as well as from the right-wing parties had argued that, if approved, the implementation of AUGE would be a failure.²⁸ In response, President Lagos, his health minister, and the leader of the Reform Commission decided to implement AUGE pilots within FONASA. The pilots began in August 2002, with three of the 56 health interventions that AUGE would guarantee (renal insufficiency, cancer in children, and congenital heart disease). The pilots generated civil and political support. Moreover, as then chief of the AUGE Technical Secretariat noted, the pilots were important “*to ensure the commitment of the Treasury*”. For then FONASA official Ghilaine Arcil (who became chief of the AUGE Technical Secretariat), the pilots were also helpful to gain implementation expertise.

Interviewees suggested that the Treasury showed commitment to fund the AUGE reform since the beginning. Former MINSAL officials point out that this was the case because AUGE was a very specified policy. In the words of Ximena Aguilera, AUGE allowed a dialogue between the Treasury and MINSAL because “*there was no black hole, but ‘these are the*

²⁸An important sector of the media sided with the right-wing parties and Isapres, such as the newspaper *El Mercurio*. Its news stories made an emphasis on the inability of the government to efficiently manage public resources. Moreover, that a clear sign of inefficiency was the scarcity of technology, hospitals, and physicians in the public health sector, which in turn would make the implementation of AUGE very hard.

pathologies, this is what we need.” Former Superintendent of Health Inostroza remarks that in some way the guidelines of AUGE made its resources guaranteed, diminishing the power of the Treasury.²⁹

A crucial decision the AUGE reformers took before the approval of the reform was that the implementation would be gradual. The demand for gradualism had different sources, from both the left and right, as well as from MINSAL.³⁰ Concertación senators pointed out the need to overcome the gaps between the demand for attention and the actual capacity of the public system. Alianza senators supported this position. They would start with 25 diseases in 2005, increase to 40 in 2006, and reach 56 by 2007. The government created the AUGE Technical Secretariat to construct the clinical guidelines establishing what could be done, together with a study of infrastructure gaps to provide a parameter of what could be implemented.

Programmatic commitment and AUGE

The process of debate of AUGE shows that a concern for parties with programmatic commitments to a policy is how they can deliver on their promises. The commitment of the major political actors developed during the process of debate proved to be important for the definition of crucial specifications of the reform regarding funding and implementation.

The Reform Commission was split up and part of it went to MINSAL to start preparing the implementation in July 2002 (just a month after the bill had entered the legislative process),

²⁹For Antonio Infante, member of the Reform Commission and then health vice-minister, the Treasury Minister Nicolás Eyzaguirre (PPD) was a “*great collaborator*”.

³⁰Ghislaine Arcil, in charge of the Healthcare Networks Division of MINSAL recounts that, together with Ximena Aguilera (in charge of the Public Health Division of the department), they went to talk with then chief of the AUGE Technical Secretariat, Patricia Frenz, to tell her that it was impossible to start with 56 pathologies. Thus, Arcil explains that they had to select which pathologies would start first “*given the real feasibility to implement.*”

while another group was in charge of getting the bills through the houses.³¹ Also speaking to this point is the fact that the government decided to create the AUGE Technical Secretariat to construct the clinical guidelines establishing what could be done. There was also a study of infrastructure gaps to provide a parameter of what could be implemented.³² According to some interviewees, including then Health Minister García (PDC), President Lagos was not particularly satisfied with the idea of beginning with less than half of the pathologies that AUGE included, but he still listened to the calls for gradualism.

Even though there were differences within the center-left Concertación coalition, there was a programmatic commitment of their members to the need of a healthcare reform, one that could bring equity and could be implemented. The disagreement of reform strategies within the coalition was ultimately solved thanks to the disciplinary power of the coalition's leader, Ricardo Lagos.³³

There were specific goals (specifications of the policy) that the Chilean parties from both left and right pursued. Whereas the political left looked to move the health system closer to the goals of equity, the right sought to defend the interests of the private sector. Lagos' government had to give in and remove the Solidarity Fund from the AUGE bill, as Concertación did not have enough votes in the Senate. Senator Boeninger (PDC) had a key role in generating consensus with the right-wing parties, a fact that is pointed out by many interviewees, including UDI Senator Matthei and Health Minister García (PDC). A point of communion between the left- and

³¹The Reform Commission was then dissolved and President Lagos appointed Hernán Sandoval Ambassador to France.

³²In the words of former member of the Reform Commission and then FONASA Director Alvaro Erazo (PS), AUGE was about providing “*effective universalism*”, which meant they did not give everything but what they did was given equally to all, instead of “*facade universalism*” where they would try to deliver everything but in poor condition.

³³This scenario is not particular to Lagos, former Concertación Presidents Ricardo Aylwin and Eduardo Frei also disciplined the members of the coalition.

right-wing parties was their interest in a feasible process of implementation for AUGE. The role of programmatic parties in Chile can help us understand AUGE in terms of its specifications regarding financing and implementation, which determined the sustainability of the reform in the long term.

Some scholars have emphasized the role that technocrats played in the policymaking process of AUGE (Farías 2014, Olavarría 2015). The Reform Commission, headed by Hernán Sandoval (PPD) had a ministerial committee (composed by the heads of the Treasury, MINSAL, the Labor Ministry, and the General Secretariat of the Presidency), with a small but important body of technocrats below it. Andrés Romero, one of these technocrats (from the Health Department), explained that they had the command to make the AUGE reform feasible, and that *“this design required a multidisciplinary work but also a very collaborative and integrated work environment.”*³⁴ Moreover, the call of gradualism, although it also came from politicians, had its source in the studies that technocrats at MINSAL had performed.

The participation of these technocrats was highly important, but not isolated from the platforms the Concertación government proposed. They had to meet the general goals of the coalition regarding the healthcare reform and could not unilaterally propose a dramatic change in the course of it. These technocrats took the overall goals of the Lagos administration and showed politicians what was feasible to do and what was the best way to do it (such as need for gradualism). Most of them had partisan affiliations within Concertación, which did not mean they represented their individual parties but rather they followed the programmatic guidelines of the coalition. As José Pablo Arellano, expert in social policy in Chile, indicated, it was important for the government to base its proposal on concrete information because it enabled a consensual

³⁴Romero detailed that if the technocrats did not reach an agreement, then they went to the ministerial committee. Then, if the ministers could not agree, they went to President Lagos.

policy. This was particularly important during the AUGE debate since Concertación did not have a majority in the Senate. Further, as Arellano stated, consensus was also important for the policy to be stable and lasting: *“The best proof of success is that the next government will maintain it.”*

The role technocrats have during the policymaking process of a reform depends on the type of parties leading such reform. In the context of programmatic parties with a commitment to the definition of a reform’s specifications, technocrats serve the purpose of developing specific goals and can put certain limits on them. In the absence of programmatic commitment, however, technocrats can serve the perverse purpose of introducing poorly specified bills.

Implementation

The long-term goal of the healthcare reforms in Chile, as in Mexico and Peru, was expanding access to healthcare services, both in terms of the population as well as treatment of different diseases. Before the AUGE reform, in 2003, 91% of Chileans were formally insured, however, as Pribble (2013) has documented extensively, there were still important barriers to effective access both in the public and private sectors. By 2016, 98% of the population had insurance.

AUGE was accompanied by a stable increase in funding for the health sector, as table 2 shows. The public health expenditure, measured as a percentage of GDP and in current USD spent per capita, as well as the budget for the reform, has grown in a constant fashion in Chile. Furthermore, the growth in formal coverage of Chileans has been accompanied by a parallel development of the required resources (infrastructure and human resources) to provide services. The programmatic party commitments to the AUGE reform, which helped to shape key policy specifications during debate, allowed for a sustainable implementation of the reform. The presence of political commitment within the parties, from the leaders in Congress and the central

government as well as at the local level, guaranteed a reform implementation that counted with the necessary resources and support at the subnational level.

Table 3.2. Funding for the Healthcare Reform in Chile

	Public Health Expenditure (% GDP)	Public Health Expenditure Per Capita (USD)	Public Budget (Million USD)
2004	2.6	158	411
2005	2.5	184	497
2006	2.5	224	595
2007	2.7	258	704
2008	2.9	299	806
2009	3.5	328	888
2010	3.3	389	1084
2011	3.3	445	1346
2012	3.5	491	1461
2013	3.6	698	1585
2014	3.9	673	1536
2015	-	661	1534
2016	-	692	1453
2017	-	-	1870

Source: Data from the Chilean Ministry of Health (MINSAL) and the World Bank

Following the schedule established in the law, in July 2005, AUGE began with 25 of the 56 planned diseases. The first AUGE decree, enacted in 2004, established the package of diseases and guarantees. The decree was to be updated every three years, keeping the same number of diseases or increasing them, based on their importance relative to the disease burden of the

country, availability and cost of interventions, and availability of resources (Lenz 2007). AUGE also established the creation of an Advisory Board, formed by experts from outside the government (from health and economy), which would change every three years. Before updating the AUGE decree, the board revises a first proposal and advises MINSAL on its applicability.

Officials from the MINSAL who were in charge of implementing AUGE recalled the meetings led by the minister every Monday to check how the implementation was going, which included officials from FONASA, the Health Superintendence and the different areas of MINSAL. They had a ledger of tasks and deadlines for each area and in these meetings they went over each task. Ghislaine Arcil, then chief of the AUGE Technical Secretariat, emphasized that they had to work with the public health services across the country, explaining to the personnel that “*while still doing what you always have, this is what you need to do in order to deliver AUGE*” in order to make sure that attention for non-AUGE pathologies would continue to work.

The Treasury gave additional funding to MINSAL for the implementation of AUGE to enhance the resources of the public sector. Over a third of this funding was for the purchase of medicines (Lenz 2007). An important part of it was also to buy more equipment and hire more personnel in order to implement AUGE. An important institution the reform introduced and funded was the Health Superintendency, responsible for enforcing the fulfillment of guarantees by both FONASA and Isapres, and supervising the performance of both insurers and providers. In the words of Pribble (2008: 232), “*the fact that the AUGE reform created a regulatory agency is an important step toward making the rhetorical commitment to universalism a practical reality.*” The creation of this new institution was accompanied by a great increase in funds. According to Manuel Inostroza, first Health Superintendent (2005-2010), his institution reached

an agreement with the Treasury: “*show [supervision] results and we will continue giving you resources.*”

In March 2006, Concertación’s leader Michelle Bachelet (PS) became president of Chile. She committed to AUGE’s continuation during the 2005 presidential campaign. According to schedule, in July 2006, the implementation of guarantees for 15 new diseases followed, and then for the last 16 (total 56) in July 2007. When they attempted to increase them to 69, the Advisory Board opposed this because there were not sufficient conditions to provide guarantees for more than 56 diseases.³⁵ There was heavy investment in equipment and hiring new health personnel to expand the public resources, which helped to contain the growth of waiting lists and the purchase of services from the private sector. Still, for Alvaro Erazo, former member of the Reform Commission, FONASA director (2000-2006) and health minister (2008-2010), they “*failed to properly project the issue of human resources*”. Ghislaine Arcil explains that for some things they accepted the lack of specialists and decided that general practitioners could perform some interventions instead.³⁶ This situation has benefited the biggest opponents of AUGE during its debate: the doctors working for the public sector.

As discussed in the previous section, worried about a decrease in their income, the Medical College carried out a strong campaign against the AUGE reform. The doctors’ fears have in part become true in the private sector, where some doctors have lost their patients as they enter into the AUGE network of interventions and providers. However, in the public sector, they have been greatly benefited. Around 60% of doctors in Chile work for the private sector, which is mostly done in combination with working for the public sector. Most of these doctors only work for the

³⁵Interview with Antonio Infante, then president of the AUGE Advisory Board (2005-2009) and former member of the Reform Commission and former health vice-minister.

³⁶Neither during the end of Lagos’ term nor during Bachelet’s was there a plan to train more specialists, even though there was a sense that they were missing in the public sector.

public hospitals and health centers during the morning, and for private clinics in the afternoons.³⁷ Given the lack of specialists in the public sector, the doctors formed medical associations oriented to specific medical specialties (i.e. traumatology) and sold their services to FONASA. Then, they can provide attention to AUGE patients at the very same public hospitals during the afternoons as part of their private practice. The doctors realized they were better paid taking care of AUGE outside the public system. As President of the Medical College Enrique Paris (2011-2017) put it, “*they have been enriched by AUGE.*” For Paris, the solution is for FONASA to be more restrictive at selecting the medical associations it buys services from, so that they do not buy from the ones that have doctors who do 11 or less hours at public hospitals.

The implementation of AUGE by the private sector went smoothly. They were able to construct the networks of providers for AUGE patients without problems. As the representatives of the Isapres Association Rafael Caviedes and Gonzalo Simon explain, they believed AUGE would not have much of an effect on the private sector, as people would prefer to continue being treated by the doctors they already knew instead of having to change by entering into a network. Nevertheless, the use of AUGE by Isapres affiliates has been increasing since it was first implemented.³⁸

Sebastián Piñera (RN) became president of Chile in March 2010. Since the campaign, the right-wing leader made it clear that AUGE would continue during his government. He even ran on the offer of “AUGE 80” during the 2009 campaign. Indeed, there was an addition of guarantees for 13 extra diseases in July 2010 (a total of 69) and finally 11 more in July 2013, making a total of 80 diseases.

³⁷President Lagos said in a newspaper interview that the doctors in Chile are socialists in the mornings and capitalists in the afternoon, which highly offended the Medical College.

³⁸The patients decide to get attention through AUGE especially for pathologies that require a large quantity of medicines. Chemotherapy is far less expensive through AUGE, so nearly 100% of Isapres affiliates with cancer use AUGE. In other cases, they rather not get into the network to be able to choose the doctor of their preference.

President Piñera's administration (2010-2014) introduced Bono AUGE, a mechanism that would allow patients on AUGE waiting lists to get attention through private providers.³⁹ The association of private clinics, Clínicas de Chile, was an important participant in the design of this mechanism. The association's General Manager Ana Albornoz noted that the idea came from her association and they put it on the table before the 2009 presidential election. An increase in the flow of new patients to private clinics began with the addition of Bono AUGE.⁴⁰ Nonetheless, Albornoz complained about the mechanism not being offered directly to the patients. Indeed, for a patient to have access to Bono AUGE, she has to go claim it from FONASA, which many do not do in part because they do not know they can. Further, for Albornoz, the medical associations that sell their services to the public sector have also diminished the flow of AUGE patients to the private clinics.

Michele Bachelet became president for a second time after winning the 2013 elections. During Bachelet's second term in office (2014-2018), the investment of funds into the health sector has been the highest in the history of the country. An important part of this budget has been directed to the development of infrastructure (hospitals and primary care centers) and new equipment. As former Chief of MINSAL's Institutional Planning Division Pietro Cifuentes noted, the high compliance rate that FONASA has for AUGE could be explained because the resources it gets every year are tied to its performance, which is an incentive to resolve issues promptly. AUGE has strengthened the primary care level, which is important to treat diseases in

³⁹The co-payments vary depending on the provider the patient chooses and it is completely free for groups A and B of FONASA.

⁴⁰Albornoz recalled that they imagined that with AUGE "*there would be an avalanche of patients to the private sector.*" However, that did not happen. The management reports of the association (published every year) emphasized this point since the beginning of Bachelet's first government, but it was not until President Piñera's term that Bono AUGE became a reality.

time as well as to transition from a system based on curative medicine to a preventive one. Moreover, this level of care is critical for low-income groups (Pribble 2013).

During her presidential campaign in 2013, Bachelet had offered a reform of the private health system. Indeed, in 2014 a special commission recommended the creation of a Universal Joint Fund (FMU). FMU is based on the same idea as the Solidarity Fund that the Lagos administration failed to include as part of AUGE in 2004. The General Manager of Clínicas de Chile Ana Albornoz and the Isapres Association representative Gonzalo de la Carrera decided to leave the negotiating table on the grounds that the FMU would make Isapres disappear. By 2018, the government has not sent any bill regarding the reform of the private system to Parliament.⁴¹

Whereas nearly 21% of the population was affiliated to Isapres in 2000, only 14.5% was by 2014. Regarding private provision, private clinics provide 45% of all the health services in the country, delivering attention to around 8 million Chileans (nearly half of the population). They provide 58% of their services to Isapres affiliates and the remaining 42% to FONASA affiliates (mainly via the free election system in which FONASA patients can choose to get attention in a private clinic with some extra payment). In terms of funding, 63% of their resources come from Isapres. If Isapres were to disappear, the public sector (through FONASA) would become the private clinics only client. For Albornoz the idea of having the private clinics integrated into the public sector is terrible, as the private clinics would be underfinanced because FONASA would not be able to pay them enough to support them.

Conclusion

The goal of AUGE was to make access to healthcare for a prioritized set of pathologies universal to all Chileans. Although most Chileans enjoyed coverage of various health conditions in theory,

⁴¹Albornoz believes—and she is not alone- that the government will not send any bill because they will just wait for Isapres to disappear by themselves given the increasing costs of health and thus their increasing premiums.

in practice their effective access to attention varied depending on the system they were affiliated to (private or public) as well as the place where they lived. Therefore, the goal of the Chilean reform was to improve the quality of access that people were getting across the public and private systems and throughout the country. AUGE attempted to create a more equitable health system by giving patients rights and guarantees for the attention they received.

A coalition formed by strongly programmatic center-left parties, Concertación, with an equity-enhancing program for health policy placed the issue of reform into the agenda. With a clear focus on the need for a reform that would make the system more equitable, the 1999 presidential campaign and party manifesto made health reform a priority. During the process of debate, a programmatic right-wing coalition defended the interests of the private sector but also pushed for a transparent plan of implementation, which included gradualism and long-term funding. Although controversial, the AUGE reformers put such issues on the table and even had to risk the passage of the law. The Chilean parties managed to enact a law that included the necessary specifications and funding to be implemented. Unlike parties that lack programmatic commitment to a reform, programmatically committed parties care about how to give feasible and sustainable solutions (good quality policy).

Farías (2014) argues that the programmatic focus of the Concertación parties was lost during the AUGE debate because this reform did not intend to change the fragmented structure of the health system (private and public) but only improve it. However, the political conditions at the time did not permit a more drastic restructuring of the healthcare system in the country. AUGE was the product of a programmatic agreement on the need for a reform that would increase access to healthcare for people, bring more equity to the system, and ultimately improve the health of Chileans.

A lot of work had to be done to be able to implement AUGE throughout the whole national territory. The implementation planning carried out during the process of debate of the reform in Chile was crucial. As Lenz (2007) points out, “*success in the political negotiation phase of a health reform does not ensure success in the implementation phase, which depends heavily on institutional factors*” (p.31), but a process of debate that focuses on clear specifications for implementation can determine the feasibility and sustainability of a reform. AUGE was accompanied by a stable increase in funding since the beginning of its implementation as well as development of infrastructure and increase of human resources throughout the country. This was possible, in part, thanks to the political commitment of the main parties in Chile, which was generated during the process of debate of AUGE. The commitment of politicians was present throughout the party apparatuses, from the party leaders in Congress and the central government to those at the local level. Therefore, in contrast to Mexico, as we will see in the next chapter, given the programmatic party commitments to the reform, there was no subnational political resistance.

CHAPTER 4: POLICY REFORM AND THE LACK OF PROGRAMMATIC COMMITMENT IN MEXICO

This chapter traces the policymaking process of the Social Protection in Health reform, known as *Seguro Popular* (Popular Insurance), enacted in Mexico in 2003. The party in government, the right-wing National Action Party (PAN), presided and implemented the reform. The Institutional Revolutionary Party (PRI) and the left-wing Party of the Democratic Revolution (PRD) were the main forces in the opposition. Political parties in Mexico are varied, with PAN and PRD relying on policy programs more than PRI, which has been categorized as a patronage machine (Kitschelt et al. 2010, Magaloni 2006).

There is evidence that the presence of programmatic parties (Stein & Tommasi 2007) as well as party system institutionalization (Scartascini et al. 2009) can help explain the success of policy reform. Based on this literature, we would expect successful reform in Mexico where they have programmatic parties and a degree of party system institutionalization (Kitschelt et al. 2010, Magaloni 2006). However, we must pay attention to how the core values of the parties relate to the policy issue in question. If these values are not connected to the policy, the party and its members will not participate in the definition of policy specifications, leading to poor quality legislation.

Furthermore, an important body of literature has focused on the role of left-wing political parties for the development of reforms seeking to expand social benefits (Esping-Andersen 1990, Huber & Stephens 2001, Murillo 2005, Pribble & Huber 2013). Based on this body of research, we should expect the development of health reform in countries such as Uruguay and Chile, but

be surprised by the same phenomenon in countries like Mexico. Although the competition from the left-wing PRD may have pushed the right-wing PAN to undertake a healthcare reform seeking to expand access (Garay 2016), the question about how that specific reform, SP, was set into the agenda, and supported by the party still remains. More importantly, how can the lack of connection between the core values of a programmatic party and the policy in question impact the quality of legislation and its implementation?

Before Seguro Popular

During the 72 years that PRI was in government, it managed to develop a strong public system of healthcare provision in Mexico, including the foundation of the Mexican Social Security Institute (IMSS) in 1943 to provide coverage for formal workers and the Institute for Social Security and Services for State Workers (ISSSTE) in 1959. These two institutes, together with the system of public clinics run by the State Health Departments, have taken care of the majority of the population as the available resources and infrastructure permitted. During the long PRI years, patronage was key to the allocation of resources in the health sector and hence the development of infrastructure for exchange of political support and jobs at these institutions was common knowledge. However, this was only one of the central problems in the sector. With the continuous growth of informality towards the end of the century, the main disparity regarding access to healthcare would be between those covered by public schemes (IMSS and ISSSTE), called “right-holders” (*derechohabientes*) and the so called “open population” (*población abierta*) without any insurance. Before Seguro Popular (SP), the “right-lacking” (*derechocarecientes*) as some sarcastically called them, received attention, when available, at the state public clinics, paying symbolic prices.

The private provision sector has grown steadily, targeting those from the middle and upper classes who were either part of the uninsured population or those who wanted to avoid the wait times and precarious services at IMSS and ISSSTE. However, the private insurance sector has had limited growth since the majority of those who can afford it are part of either IMSS or ISSSTE. The Mexican Foundation for Health (Funsalud), founded in 1985, is a civil society research organization formed and financed by the health business sector; its board of directors includes representatives of both the provision and insurance companies, such as the National Association of Private Hospitals and the Mexican Association of Insurance Institutions. Under the leadership of Guillermo Soberón (PRI), who was president of the organization from the end of his term as head of the Health Secretariat (1982-1988) until 2004, Funsalud has been involved in some of the most important PRI health policies such as the IMSS reform in 1995⁴².

Soberón, one of the most influential PRI figures in health, worked closely with Julio Frenk, vice-president of Funsalud. Frenk was in charge of Funsalud's Economy and Health project during the early 1990s, which produced a report in 1994, and was the main precedent to SP. The report focused on the disparities of the healthcare system, across states and across schemes, and the need to increase public spending and to reduce out-of-pocket expenses (which accounted for over 50% of health spending). Therefore, it proposed a protection mechanism for the uninsured population that would particularly tackle expenditures due to catastrophic events, which sent many families below the poverty line. The proposal did not receive much attention from the Zedillo administration (1994-2000). Frenk then moved to the WHO to set another important precedent for SP: the 2000 World Health Report, which praised the Colombian reform in terms

⁴²Until then, the affiliates' contributions to IMSS would depend on their salaries; with the 1995 reform the contribution would be the same for all affiliates.

of financial protection and the separation of functions (financing and provision) within the system.

After decades in power, PRI finally lost the 2000 presidential election against PAN's candidate Vicente Fox. During the presidential campaign, little was said about health. Instead, the democratization of the country was at the core of the debates, with PRD and PAN advocating for the removal of PRI from power. When Fox was elected president, although some members of his Cabinet were Panistas, the majority came from outside the party (PRI and independents), among them, Julio Frenk as head of the Health Secretariat. The reform of the sector was a latent issue due to the fragmentation of the system and the lack of resources. By 2003, 54% of the population was uninsured, whereas IMSS and ISSSTE were covering those with formal jobs (44%) and only a small minority had a private insurance (2%). Moreover, international organizations such as the World Bank, the WHO and the PAHO raised the awareness of governments of the need for an expansion of healthcare.

The health reform introduced in Mexico had two main long-term goals: 1) expanding coverage of the population and 2) gradually increasing coverage of health conditions by guaranteeing access to treatment for a set of diseases, and hence level the benefits across schemes. PAN, the programmatic party in power, was marginally involved in the policymaking process of SP because the reform was not related to its core values. As a result, in Mexico, technocrats rather than political parties placed the issue into the agenda and there was a lack of political commitment from the main parties to the reform. PAN did hold a core value uniting its leaders: Catholicism (Hawkins et al. 2010, Magaloni & Moreno 2003). However, this value did not relate to the issue of healthcare reform and hence PAN members remained detached from the policymaking process of SP.

Agenda-Setting

PAN did not introduce the issue of healthcare reform into the agenda nor shaped the specifications of the reform but only supported it under the command of its leader, President Fox. Both members of the Health Secretariat as well as of PAN agree that there was no participation of the party. Health was not a key issue of PAN's agenda neither during the electoral campaign or the first years of government.⁴³

Health Secretary Julio Frenk introduced the health reform proposal into the political agenda in 2000. Frenk did not have any partisan affiliation, although he was close to PRI but not to the party in government, PAN. Frenk had worked on this proposal since the early 1990s while with Funsalud. Frenk formed a small group of people in charge of the design of SP and began lobbying legislators and state governors to gather support for the reform. SP –although under a different name initially- would provide protection to the uninsured population with a set package of benefits for certain health conditions. According to Frenk and his team, having a set package of benefits was important in order to make the right explicit and determine how much money they would need.

The Health Secretariat's Strategic Planning Office crafted the first draft of the program (called "Health for All"), which emphasized the need to switch from a supply subsidy type of system to a demand subsidy system and to advance towards an integrated public system in which the federal government would be the single public payer and there would be different providers.⁴⁴ This plan left the private insurance and providers untouched. During 2001, the office continued to develop the details of the reform and eventually gave it the name *Seguro Popular*.

⁴³Neither were education and even the fight against poverty.

⁴⁴The integration of the public system under a single financial institution (rather than a system composed by IMSSS, IMSSTE, etc.) was a model that lots of experts favored but realized that politically it would not be feasible.

In terms of the provision of services, SP affiliates would get attention through the public clinics run by the state governments.

The secretariat carried out a SP pilot before sending the bill to Congress; its implementation began in 2001. They selected five states for the pilot (Aguascalientes, Campeche, Colima, Tabasco, and Jalisco), based on the fact that they were relatively small, had some infrastructure, an important segment of uncovered population (but not unmanageable), and the disposition of the State Health Secretariats to collaborate. Further, as then head of the Financial Protection Direction Héctor Hernández noted, it was also important to go “*where they could make allies for the future debate of the bill*”. Only two of the five states were PAN (Aguascalientes and Jalisco), whereas the remaining three were PRI. The goal was to have as many families under SP as possible in each of the pilot states before Congress started to debate the reform. As mentioned by one of the key members of the Strategic Planning Office, Mariana Barraza, the pilot was important to define the amount of resources necessary per family and, in the future, ask the Treasury for such resources. In the words of Frenk, the pilot was also “*intended to show the Executive that the Health Department could work with the state governments*” because there was skepticism regarding the feasibility of this, particularly with rural states in which “*the concept of insurance was foreign*”.

In November 2002, the Executive sent the bill to the Senate, which also included the creation of the National Commission for Social Protection in Health (CNPSS) to be in charge of implementation.⁴⁵ The state governments would be in charge of the development of infrastructure needed for SP, with the federal government in charge of assigning resources and supervision.

⁴⁵In Mexico, the Executive can decide whether to send the bill to the Senate or the House. Members of the SP team noted that they sent it to the Senate because the debate would be easier with a reduced number of MPs.

One of the major objections SP had to face was the opposition of the Treasury, which was crucial to its feasibility. The bill needed the Treasury's approval, both formally (the president could not send bills to Congress without a signature from it) and informally (in order to stand a chance of surviving the vote in each chamber). The SP team held several meetings with the Treasury to discuss the budgetary implications of the reform and state that SP was going to be a responsible and gradual reform.⁴⁶ Then Treasury Sub-Secretary Carlos Hurtado noted that the percentage of uncovered population was so large that *"SP would cost too much... We didn't want that reform because it was very expensive... We didn't have the payment sources."* However, the SP team managed to get a signature from them. When the bill arrived to the Senate, the Treasury openly opposed it.

Still, Frenk and his team felt confident before sending the proposal to the Senate as, in part thanks to the pilot, they had managed to gather a lot of support from state governments. In the words of Frenk's Coordinator of Advisors, Miguel Lezana: *"Most governors, when they saw that with the reform they were going to get more money, they bought it."* PRD governors were not the exception: Ricardo Monreal, PRD Governor of Zacatecas became one of the main advocates of SP. From PRI, a key ally at the state level was Governor of Nuevo León Zacarías Villarreal, who stated: *"We did the lobbying with our federal deputies and senators... Every state had their fingers crossed for SP to be approved."* The implications of this support are discussed in the next two sections.

Before the SP bill arrived to Congress, it already had an important alternative proposal: a PRD group in the Mexico City Government began the implementation of the Free Medical Services and Medicine Program (PSMMG) in 2001. The program sought to guarantee access to health services (primary care and some specialties) to the uninsured population living in Mexico

⁴⁶Interviews with Health Secretary Julio Frenk and member of the Strategic Planning Office Mariana Barraza.

City. One of the long-term goals of the program was to integrate the social security system and the PSMMG so that both groups would enjoy the same degree of benefits. Led by the Federal District's Health Secretary Asa Cristina Laurell, one of the most influential PRD figures on social policy, the program looked to move towards a non-contributory universal scheme financed through general taxes.⁴⁷ SP and PSMMG are two strategies of tackling the lack of protection of the uninsured population in sharp contrast. Whereas SP involved a contribution from the affiliates –as discussed in the next section-, PSMMG was completely free. Moreover, in contrast to SP, the Mexico City program was devised as a step towards a unified healthcare system that would provide the same benefits levels across the different segments of the population (formal and informal workers).

If there is a key conclusion to make from the agenda-setting process of SP it is that PAN did not participate. Technocrats from Funsalud, a think tank financed by the private sector, introduced the reform into the agenda. Both members of the Health Secretariat as well as of PAN agree that there was no participation of the party in the content of the bill, but that the main role the party had was to support the bill and make it pass in Congress. In the words of many of my interviewees, Frenk “convinced” President Fox to go for SP, a proposal that Fox later used as a flagship of his government. However, health was not a key issue of PAN's agenda neither during the electoral campaign or the first years of government. At the core of PAN's ideology were Catholicism and democracy (anti-PRI). However, health, education and even the fight against poverty were not main issues during the 2000 presidential campaign. For one of the SP team members, the lack of participation of PAN was a lucky thing because these politicians “*would have contaminated [the process]*”; instead “*they let [the team] work.*”

⁴⁷Laurell was close to Andrés López Obrador, former PRD president and head of the Government of Mexico City (2000-2005), and was in charge of the party manifesto.

There was a sector of PAN that was not particularly content with Frenk being named health secretary. The most conservative part of PAN, El Yunque, opposed the liberal leanings of Frenk regarding reproductive rights. Nevertheless, Fox stood strong in his selection throughout his term.⁴⁸ El Yunque also opposed policies targeted at the poor since, for them, policies should aim to enlarge the formal economy, which would in turn diminish poverty. Several interviewees noted that the Fox administration was in the search for new projects, as PAN did not have a team of experts on health. They also mentioned that this is the reason behind PAN members never participating in any of the technical meetings regarding SP.

Debate

The healthcare reform in Mexico was not directly related to the core value of PAN, Catholicism, and therefore the party had no programmatic commitment to the reform. If we think of the Mexican parties through a dichotomous frame (programmatic or not), we would expect PAN to behave programmatically. However, this was not the case and the party was detached from the process of debate. This defined the process and the content of the final law that was approved. In the words of a member of the SP team, *“the legislature did not introduce any important changes.”*

Technocrats filled the void that the lack of participation of the parties left in Mexico. Health Secretary Frenk, former Funsalud leader, led a group of experts that controlled the process of debate around the reform. The lack of interest of party representatives in the process of debate meant that they did not push for clarity in terms of funding and infrastructure, leading to a poorly specified bill, and equally important, a lack of political commitment to the implementation.

⁴⁸This support was put to the test with the case of the morning after pill (which started to be distributed by public clinics at the end of 2004) and different conservative sectors asked for Frenk's resignation.

The SP team felt the pressure of needing to get the bill approved before the end of the legislative term on April 30th 2003, in which new deputies would take the seats in the lower house. PAN did not hold a majority in the Chamber of Deputies but they knew that, most probably, the new chamber was going to have an even smaller proportion of PAN members.⁴⁹ Moreover, the team knew that trying to introduce the reform further into Fox's term was going to be difficult, as the administration would be more worn out. As different members of the Frenk team mention, the reform would have died if it had not been approved during that term.⁵⁰ In that context, the SP team decided that some of its key members had to be devoted to ensuring the bill was approved. An important unit within the Health Secretariat for this matter was the Social Bonding Office, in charge of lobbying state governors and state health ministers, as well as legislators even before sending the proposal to Congress. Funsalud was also important for the dissemination of the SP proposal across the different states via workshops with authorities and academics. In the words of a Funsalud member, "*Funsalud has always been a relevant player in the health policy of the country, especially because it has financing from the main businesses of the country.*" The joint committees in the Senate only approved a draft on April 23rd 2003.

The ruling party PAN gave its absolute support to the SP bill, but it had no participation in the definition of its specifications. In the words of then President of the Health Committee in Congress María Galván (PAN), "*PAN gave all its support to Dr. Frenk's initiative.*" She also recalled the meetings they held with Secretary Frenk and other members of the SP team, which, in her own words, were not necessarily discussions but meetings "*to create awareness and*

⁴⁹206 PAN, 209 PRI, 53 PRD, 32 others.

⁵⁰In the words of the Head of the Social Bonding Office Gabriel García: "*an initiative you put back into the drawer cannot be taken out again.*"

review legal details”. All PAN members voted in favor of the bill in both houses.⁵¹ However, as noted, the party did not have enough votes to pass the bill and hence needed the support of legislators from the other two main parties: PRI and PRD.

PRI and the Treasury

PRI votes were extremely important in order to approve SP (they held 60 out of 128 seats in the Senate). Members of the Frenk team noted how much work they put into lobbying PRI representatives. SP had partial support of PRI, including Beatriz Paredes, an important figure within PRI (party president 2007-2011) and then president of the Chamber of Deputies. A key factor that won PRI’s support was the large increase in resources for state governments that SP entailed, which have always been important for patronage. María de las Nieves García was the Deputy in charge of convincing her PRI fellows to vote in favor of SP. Moreover, Frenk and members of his team had ties to the party, which according to the accounts of some of its members, was a clear advantage.

A key point of PRI opposition was tied to the Treasury.⁵² Then Deputy Jorge Chávez (PRI) noted that several PRI deputies “*acted in coordination with certain institutions such as the Treasury, IMSS and their state governments.*” The Treasury felt that there were not enough resources for SP and even demanded a specification in the law stating that if in a certain year there were not enough resources, the Treasury would not be forced to contribute. Although then Treasury Secretary Francisco Gil (PRI) remained removed from the process, Sub-Secretary Carlos Hurtado did “*the front line battle*”, as he called it. Hurtado affirmed that they had “allies”

⁵¹The only PAN Deputy who was present and did not vote was Francisco De Silva.

⁵²Lakin (2008) shows that the electoral system (SMD versus PR) under which the deputies are elected, whether the deputies are from states with PRI governors, or from poorer states or states with a larger open population did not define their votes.

in Congress and stated: “*In theory, if Fox sent the bill, his ministers were on board... but it was not the case, we [the Treasury] hijacked the proposal.*”⁵³

In Mexico, it is a common practice for the Treasury to place deputies -usually from PRI-, so that they can gain approval for initiatives that the Treasury them and to take care of the annual budget, which the Chamber of Deputies approves. Whereas all PRI deputies in the Health Committee voted in favor, that was not the case for members of the Finance Committee. The Treasury had contacts with PRI people in this committee and they all voted against the SP bill.⁵⁴ Whereas all PRI members voted in favor of the bill on the Senate floor on April 24th, on April 29th, in the Chamber of Deputies, 102 PRI members voted in favor and 58 voted against.

Hurtado noted that one of President Fox’s advisors called him to say that this was enough opposition and Secretary Gil instructed him to stop the resistance in the Senate. The arrangement was that the bill had to include a transitory article stating that families would be affiliated to SP in a gradual manner. The SP team decided that the unit of insurance should be the family as opposed to the individual, in order to mirror the social security system schemes. Also mirroring IMSS and ISSSTE, SP would have 3 main sources of funding: 1) a Social Contribution, per family paid by the federal government, and instead of the workers’ and employers’ contributions, 2) a State Solidarity Contribution paid by the state governments, and 3) a Federal Solidarity

⁵³Galván (PAN) recalled getting phone calls from Treasury members to convince her of the disadvantages of SP.

⁵⁴Oscar Levin -who joined the Treasury right after his legislative term-, Salvador Rocha, José Ugalde, Guillermo Hopkins, and Jorge Chávez Presa –who had worked for the Treasury for years.

Contribution.⁵⁵ Moreover, the Health Secretariat would need to define the Family Contribution, which each family, depending on their income, would pay.⁵⁶

PRD and the opposition to the role of the private sector

SP had to face the opposition of a sector of the left-wing PRD. The President of the Health and Social Security Committee in the Senate, Elías Moreno (PRD) was one of the main opponents to the reform. Moreno refused to include the discussion of the bill in the agenda, arguing that since Health Minister Julio Frenk was a candidate for Director-General of the WHO, they had to wait to see the outcome of the election in January 2003. Several interviewees mentioned the fact that Frenk was running for this position showed a lack of commitment to the reform and that it gave uncertainty to the process: had Frenk been elected, the whole reform would have collapsed. Moreno was one of the main speakers of the PRD sector that opposed the bill in the Senate. This sector advocated for a unified system that would mirror the PSMMG implemented in Mexico City since 2001. PRD, however, never presented an alternative proposal to SP in Congress.

The party was divided at the time of the vote in the Senate in April 2003: 7 senators voted in favor and 7 against the bill. The PRD sector in favor of SP supported the important increase in resources that would reach the states thanks to the reform. Senator Demetrio Sodi (PRD) was one of the main advocates of the SP bill. Sodi and the Governor of Zacatecas Ricardo Montiel were the only PRD members that openly supported SP during its legislative process.⁵⁷ Their argument was based on the important increase in resources that would arrive to the states thanks to SP. In

⁵⁵The Social Contribution was established to be 15% of a minimum salary in Mexico City. The State Contribution was 0.5 times the Social Contribution, whereas the Federal Contribution was 1.5 times the Social Contribution.

⁵⁶Although the Family Contribution was not a main part of the way SP was going to be funded. According to some members of the Frenk team, this was important “in order to generate a sense of ownership of the program and a citizen culture for the demand for good quality of care in the affiliated population.” (Octavio Gómez).

⁵⁷Sodi had been a PRI member until 1994, and then joined PRD in 1997. In 2005, joined PAN and run as its candidate to be head of the Mexico City Government, losing to the PRD candidate. Montiel had also been a PRI member until 1998.

the words of then Director of Planning at the Mexico City Health Secretariat Oliva López (PRD), “*that was the carrot for governments strangled by the lack of resources... those senators had a pragmatic position.*” Different interviewees mentioned that this was the main reason behind the favorable vote of the other PRD members. According to members of the Mexico City Government, they met with the party legislators to explain why they should vote against the SP bill, but the legislators also faced the pressure of their governors who were convinced that SP would bring more resources to their states.

In contrast, for several PRD members, SP would lead to the gradual privatization of the health system since the public sector would not be able to cover the demand for services alone. They also considered that having a package of interventions for specific health conditions was discriminatory to those who suffered illnesses outside of this set.⁵⁸ This sector also considered that the Family Contribution was part of the idea of health as a service to purchase instead of a granted right. The Frenk team tried to “reconcile” the first point and stated in the bill that only public institutions could provide services for SP, but, in the words of then Legal Affairs Director at the Health Secretariat, Ignacio Ibarra, “*the play was to include it in one part [of the bill] but not in the other.*” Different members of the Frenk team mentioned that they did not want to deal with the “privatization accusation” as it could bring the bill down. For Frenk, this was part of granting citizens freedoms, such as the freedom to use private sector services (Ortiz 2006).

PRD voted as a block on the floor of the Chamber of Deputies. These PRD deputies were about to leave office and they had to be disciplined and follow the party lines if they wanted their political careers to continue. As some studies show (Langston 2010), the main way in which the three main parties in Mexico discipline their legislators is via nominations. This is particularly

⁵⁸Even though the bill did not specify how many interventions SP affiliates would be covered for, it did state that certain interventions would be prioritized.

the case of deputies since they cannot be reelected and therefore need to stay on good terms with the leadership of the party in order to be able to get nominated for local positions. Moreover, the main figure of PRD at that moment was head of the Mexico City Government, Andrés Manuel López Obrador, who was at the peak of his popularity and had great chances of winning the 2006 presidential election.

The role of the private sector was not very salient in Mexico. As was the case in Chile and Peru, the private provision sector knew it could benefit, as the public sector would be unable to respond to the new demand for services.⁵⁹ Without any public display of their support, they were connected to the policymaking process of SP through Funsalud, the organization that gave birth to the core ideas of the reform. Key actors from the private sector were part of Funsalud's board of directors.

Infrastructure and resources

The SP bill included an article stating that the federal government had to “*assign the necessary resources for the maintenance and development of infrastructure and equipment*”, in alignment with the Infrastructure Master Plan the Health Secretariat had to craft, as stated in the 2001-2006 National Health Program. As Frenk noted, this plan would help to change a system where decisions regarding new infrastructure were politicized. This was, nevertheless, not part of the debate of the SP bill. PAN members and PRI members in favor of the reform argued that the new resources that SP would bring would help to deal with the lack of infrastructure the public sector faced. From the opposition, PRD was mainly focused on the possible privatization of the system and the discrimination that a package for a set of illnesses would cause. However, the lack of

⁵⁹Even though the Mexican Association of Insurance Institutions did not participate in the legislative process, it has been a lot more active since the beginning of the SP implementation, trying to complement the coverage provided by SP with private insurance schemes.

infrastructure would be a highly prominent issue during implementation, which is discussed in the next section.

The funding of SP was not an important point of debate during the legislative process of the bill. The Treasury had legitimate concerns regarding the availability of resources to fund SP. However, neither of the parties propelled a discussion regarding the specific sources of funding for the reform. Only individual legislators from PRI showed their opposition due to financial reasons, and one PRD senator pointed out the large quantity of resources and responsibilities the Health Secretariat was going to transfer to the state governments for the provision of services, putting all the weight on the state governments. The Frenk team and PAN members argued that the gradual implementation of the reform would prevent running into an insufficiency of resources. As a member of the Frenk team noted, the high prices of oil at the time were favorable to continuing with a reform without making any fiscal changes.

One of the key factors behind the support for SP across parties was the support of state governors due to the new monetary resources SP entailed. In the words of García Pérez, “*how would governors in states without resources dislike SP?*” However, several governors showed reticence to having to provide the State Solidarity Contribution once the law was approved and its implementation had to begin.

On April 30th, the Senate finally approved the bill with 88 votes in favor and 6 against (all from PRD). During the SP debate, Mexico had strong political parties: well funded, disciplined, with offices across the country, and the ability to capture a large percentage of the vote.⁶⁰ PAN had a core value uniting its leaders, Catholicism, but SP was not directly related to this value,

⁶⁰Party leaders in Mexico are generally able to command the votes of their members.

and therefore the party remained distant from the debate process.⁶¹ Although the party members were disciplined and supported the bill, they did not attempt to shape important specifications for the implementation of the healthcare reform. Neither did PRI, a party without core ideological values. Whereas some PRD members opposed SP, they could not influence the vote within the party or the final decision. Consequentially, parties did not shape the specifications of the Mexican reform and a commitment to SP and its implementation was never forged among the main political parties.

Implementation

The long-term goal of the healthcare reform in Mexico was to expand access to healthcare services, both in terms of the population as well as treatment of different diseases. When we look at the results of the implementation, there was definitely an impressive increase in people covered: whereas 46% of the population was insured before the 2004 reform, 93% was formally insured by 2016. However, this increase in formal coverage has not been met by a parallel development of the required resources (infrastructure and human resources) to provide services, which poses constraints to effective access of those covered “on paper”.

The budget for the reform in Mexico, as well as public health expenditure, measured as a percentage of GDP and in current USD spent per capita, has not been constant. As table 1 shows, the budget in Mexico saw a reduction of over 4% for 2017 and an increase of 1% for 2018. The lack of commitment from the main political actors in the process of reform in Mexico led to a poorly specified legislation in terms of funding and infrastructure development necessary for an effective implementation.

⁶¹PAN generally advocates for a market economy, but when it comes to healthcare, it does not have a defined partisan alignment.

Table 4.1. Funding for the Healthcare Reform in Mexico

	Public Health Expenditure (% GDP)	Public Health Expenditure Per Capita (USD)	Public Budget (Million USD)
2004	2.7	192	403
2005	2.6	201	803
2006	2.6	218	1560
2007	2.6	243	2337
2008	2.8	262	3349
2009	3.1	229	3376
2010	3.1	270	4052
2011	3.1	299	5043
2012	3.2	310	5339
2013	3.3	339	5971
2014	3.3	321	6235
2015	-	291	5404
2016	-	257	8126
2017	-	192	7721

Source: Data from the Mexican Health Secretariat and the World Bank

For the implementation of SP to begin in January 2004, given the autonomy of the states, each one of the 31 state governors and the head of the Federal District had to sign “coordination agreements”. By December 2003, 7 months after the approval of the law, no single governor had signed the agreement. The main reasons: 1) their reticence to provide the State Solidarity

Contribution and 2) the reduction of their ability to control the distribution of resources.⁶² Along those lines, then Health Secretary of Chihuahua (one of the last states to sign) and Director of the National Commission for Social Protection in Health (CNPSS) Javier Lozano affirmed that the resistance to sign in his state was due to the State Solidarity Contribution.

During debate, the SP team managed to convince the state governors by emphasizing the transfer of fresh monetary resources. They re-emphasized this point in order to convince the governors to sign the agreements and negotiated *how* the state governments could provide their contributions. They promised the governors that other things could count towards them, and that they would only start contributing in cash in 2010.⁶³ Members of the team and Frenk himself affirmed that this was the only way to gain the allegiance of the governors. As SP team member Mariana Barraza noted, they did not foresee the reticence of state governors to contribute to SP during the legislative process.⁶⁴

The way most resources were transferred from the federal government to the states was through the State Treasuries, led by personnel close to the governors. Then these treasuries would transfer to the public clinics in their states according to their needs. SP introduced a new mechanism: the State Regimes of Social Protection in Health (REPSS), a new financing institution which was to receive the monetary resources for SP and pay directly to the public clinics in the states. REPSS were meant to be autonomous from the state governments. Once the implementation of SP started, the state governments made sure that they were able to name the head of the REPSS so that they could retain their distributive power. The Director of the

⁶²The case of the Government of Mexico City (GDF) was different. Frenk noted that GDF Health Secretary Asa Laurell was the main actor behind the resistance, because SP represented a threat to PSMMG. Indeed, given this fear, Laurell's team proposed a couple of options: 1) granting Mexico City citizens the option to choose between the two, 2) the GDF having the option of using the funding destined for SP for their own program. The Health Secretariat rejected both proposals.

⁶³Soccer fields, fountains, roads, and drains could count as "contributions".

⁶⁴In her words, "*if you see how to implement beforehand, nothing would get done.*"

Economic Analysis Unit at the Health Secretariat noted: *“When the first [governors] that signed realized that they could ‘cheat’ the system, the others began to sign”*.

These arrangements between federal and state governments regarding what would count as contribution and the independency of the local SP offices hurt the sustainability of the reform. SP funding was reduced and there is a lack of accountability of state governments, which have become two of the major obstacles for the implementation of the reform. Even though the SP bill stated that the federal government holds the states accountable for the use of the resources transferred to their treasuries for the development of infrastructure and the resources transferred for the purchase of services, this does not happen in most cases. According to official data from the Health Secretariat, most states only report 50% of the use of SP resources; and some of them do not even report at all. Member of the Frenk team, Gabriel García asked himself during personal interview: *“What did we lack? Clear rules of financial operation... there should have been a more permanent management of the cohesion between states and central government.”*

The Health Secretariat established the National Commission for Social Protection in Health (CNPSS), in charge of the implementation of SP in January 2004. Their very first task was to decide which interventions SP would cover, based on the cost of treatment, availability of provision and prevalence of the illness. This set, the Universal Catalogue of Health Services, originally had 154 interventions, and it grew gradually (249 in January 2006, 257 in 2010, and 287 in 2017). The catalogue includes all primary care level interventions, but has stagnated with the same number of interventions since December 2014, although there has been expansion in terms of the medicines included in the coverage of SP. Furthermore, SP would provide coverage treatment for some complex health conditions that could potentially lead to catastrophic

expenditures, through the Catastrophic Expenses Protection Fund (8% of SP funds are allocated to the fund).

The number of families affiliated to SP saw rapid growth during Felipe Calderón's term (2006-2012), growing to over 43.5 million people by December 2010 (37% of the population), according to official reports of the CNPSS. The budget assigned for the reform also grew, as shown in table 1. The fact that SP provided new resources to the health system in Mexico is undeniable. However, the Treasury introduced a reform to the SP bill in 2010 that changed the Social Contribution provided by the federal government.⁶⁵ All states, without exception, lost a significant quantity of resources (Laurell 2013). According to official accounts, this was a necessary change since the states were affiliating the same individuals as part of different families. This has been highly contested as many argue that the Treasury introduced this modification due to a lack of funds.

The reduction of resources caused by this change, added to the fact that many states do not contribute the whole amount of their contributions, has been one of the major problems faced by SP. Moreover, the Family Contribution was established to depend on the income of the family, with families from socioeconomic deciles I and II being exempt from the payment. However, the majority of state governments exempted nearly all affiliates from such contribution as they realized that they could exempt everyone of such charges as an incentive for affiliation: the more affiliated families, the more resources transferred. Members of both the CNPSS as well as members of the Health Secretariat's Economic Analysis Unit acknowledged this whole situation. However, the lack of funding is not the only problem SP has faced. A shortage of infrastructure and human resources has prevented SP affiliates getting coverage for those interventions that they are "in theory" protected for.

⁶⁵From 15% of a minimum salary in Mexico City assigned per family, to 3.92% assigned per individual.

With the increase in affiliation, the demand for services went up, but the development of infrastructure and increase in human resources did not advance at the same rate. This imbalance has affected the level of effective access for SP affiliates, particularly in rural areas where people might be affiliated but no public clinic is close to them so they have to be referred to a different location. There are striking differences in terms of infrastructure and effective access across states in Mexico.⁶⁶ The reduced funding has made it impossible to develop more public clinics in areas that lack access as well as provide the necessary equipment to clinics already in place. Moreover, several state clinics are unable to provide access to medicine, with some of them only satisfying the demand of 22% of patients, according to official data from the Health Secretariat. The National Survey on Satisfaction and Adequate Treatment shows the same results, that most people cannot access the medicine they need, which is the main cause for such high out-of-pocket expenses and the dissatisfaction of SP affiliates.⁶⁷

The purchase of private services for SP interventions has not seen a lot of progress. The state governments prefer to buy from their own public clinics and are reticent to buy private services.⁶⁸ As noted by the General Director of Centro Médico ABC Alejandro Alfonso, one of the most important private providers in the country, the sector is interested in selling to SP in order to use their idle installed capacity, but what SP pays is not enough to even cover the cost of production. For ABC's Vice-president Guillermo Reyes, SP should become a step to transform the system: state as the payer and the private sector as the main provider, "*a sector that is more*

⁶⁶For instance between Nuevo León, with around 90% of its population in urban areas, which facilitates access to public clinics, versus Chiapas that is mainly rural and has one of the most precarious infrastructures in health.

⁶⁷As a PAN member who worked for the CNPSS accurately stated, "*SP is just rhetorical because people arrive with their credentials to get attention but cannot access it because of the lack of infrastructure.*"

⁶⁸According to several interviewees, the progress towards the subrogation of services for SP has been slow because the government has to be cautious to prevent being accused of privatization of the healthcare system.

efficient and with better quality".⁶⁹ Meanwhile, the Mexican Association of Insurance Institutions has been very active in recent years, in collaboration with Funsalud, trying to propose complementary insurance schemes that those covered by SP could buy.

By providing financial protection to those from the uninsured population, SP could gradually close the gap between those who were part of the social security system and those outside it. Indeed, the differences in public spending per capita for social security members versus the SP population have reduced. However, the gap to be made up in infrastructure and resulting limitations in effective access to healthcare experienced by SP affiliates has not allowed for these two different segments of the population to come closer. It is important to note that the differences in public spending per capita between the two segments have reduced: the government spent 2.15 times more per capita for social security members than for those uninsured in 2000 (before SP) and 1.5 more in 2009 (Flamand & Moreno 2014).

In 2014, the Health Secretariat sought to introduce a key modification to the SP bill in order to tackle the perverse relation between the REPSS and the state governors: the Health Secretariat would designate the head of the REPSS instead of the governors. The governors strongly opposed it, and the only modification the secretariat was able to introduce was that they would provide a profile of the most suitable heads the governors could name. In 2015, the Treasury introduced different measures to reduce the autonomy of the states and bring more efficiency to the use of resources.

Conclusion

In a country where half of the population had no healthcare protection, the goal of SP was to provide coverage to that segment of the population. In that way, SP sought to solve the

⁶⁹Reyes also mentioned that no party assumed the representation of the private sector. In his own words, "*parties cannot be trusted as long-term allies.*"

fragmentation of the Mexican healthcare system and reduce the gap between the “right-holders” –as they call them- under the social security system and those outside the formal economy. These noble goals, however, have been constrained by a lack of funding, shortage of infrastructure and low levels of accountability at the state level.

At the core of the right-wing PAN’s ideology was Catholicism. The healthcare reform was tangential to this core value. Consequently, the party did not introduce the issue of healthcare reform into the agenda, which members of PAN itself and the Health Secretariat affirmed. The issue of health was not part of the party program, neither during the 2000 presidential election nor during the first years of government. Instead, a small group of technocrats led by Health Secretary Frenk (former vice-president of Funsalud, a think tank financed by the private sector), placed the reform into the agenda.

There was no participation of PAN in the content of the bill, that only role of the party was to make the bill (“*Dr. Frenk’s initiative*”, as they called it) pass in Congress. PAN did not care to shape key specifications of the reform, such as funding and infrastructure. An important sector of PRI and of PRD supported SP due to a large increase in resources for state governments that SP entailed, but did not seek to craft a reform that could be implemented effectively and could be sustainable over time. The lack of programmatic commitments from the Mexican parties hampered the success of SP. Two of the main obstacles the implementation of SP has faced are the instability of funding and insufficient infrastructure to provide healthcare access to SP affiliates. Although more Mexicans enjoy formal coverage thanks to SP, there is a shortage of means to effectively provide such coverage.

The Mexican case shows that when political parties lack commitment to a policy reform, even if these are strong and institutionalized, individual technocrats can dominate the

policymaking process and lead to poorly specified legislation and a deficient implementation. A policy designed by technocrats still needs to be carried by committed politicians during its implementation to succeed. SP fell short at its implementation stage because instead of trying to work with the state governments, the reformers just convinced them to support the reform by promising resources and granting them conditions that allowed the governors to maintain their power. From their desks in Mexico City, the SP team did not foresee the huge implementation problems SP would face.

CHAPTER 5: POLICY REFORM AND THE LACK OF PROGRAMMATIC COMMITMENT IN PERU

In this chapter, I focus on the Peruvian healthcare reform approved in 2009, Universal Health Insurance (*Aseguramiento Universal en Salud*, AUS), debated in Congress during Alan García's last term (2006-2011). Although called "universal", this policy did not aim to provide the same entitlements to the whole population, but instead provide what Martínez Franzoni & Sánchez-Ancochea (2016) refer to as an "instrument" to achieve universalism. AUS would help achieve widespread insurance coverage of the Peruvian population and expand access to healthcare.

The party in government, APRA, had originated as a left-wing party in the 1920s and then shifted towards the right in the subsequent decades, which was particularly clear during García's last term. In opposition, APRA had the left-wing coalition between Union for Peru (UPP) and the Peruvian Nationalist Party (PNP), as well as the right-wing coalition National Unity (UN).⁷⁰ Peruvian parties were characterized by the use of charismatic and clientelistic appeals to attract support from the population rather than policy programs as well as by their lack of institutionalization (Cameron 2011, Kitschelt et al. 2010, Levitsky 2013, Levitsky 2018, Levitsky & Cameron 2003, Tanaka 2005). *How are reforms adopted in the context of non-programmatic parties and what are the consequences?*

The context of the Peruvian case deviates from similar attempts to expand access to healthcare. Unlike AUGE in Chile, Left-wing parties in Peru were extremely weak during the

⁷⁰The UPP-PNP coalition was formed to support the presidential candidacy of Ollanta Humala who lost the election to García in 2006. UN formed before the 2001 presidential election and presented Lourdes Flores as its candidate; the Christian Popular Party (PPC), National Solidarity and National Renovation composed it.

policymaking process of AUS. Furthermore, in contrast to AUGE, as well as to Seguro Popular in Mexico, the Peruvian reform was developed under parties that were far from programmatic. This unexpected appearance of reform can enlighten our knowledge of social policy reform and the policymaking process. We must understand what explains 1) the emergence of reform in these cases and 2) the quality of reform approved and implemented. If right-wing parties are presiding attempts to expand healthcare access, regardless of whether these attempts are successful or not, it is important to understand how and why.

The findings of this paper contribute to the literature on social policy reforms by pointing out how the lack of programmatic commitments of the parties can have an effect on the policymaking process and final policy. I show how non-programmatic parties affect policymaking and final policy. Peru, described as a “democracy without parties” (Levitsky & Cameron 2003), helps us understand how weak parties, without core values, lead to low quality policy that has no political commitment to sustain it.

Expanding the study of healthcare reforms to cases in which non-programmatic parties presided and carried out reforms can allow us to better understand the role of important actors such as technocrats and the private sector. As shown by Dargent (2014), the degree of autonomy of technocrats in the health sector in Peru has changed across time. While technocrats enjoyed a great degree of autonomy during the 1990s, it decreased in the early 2000s since international financial institutions (IFIs) “gradually lost interest in health policy reform” (p.135). However, during the policymaking process of AUS, technocrats without partisan ties from the United States Agency for International Development (USAID) enjoyed a great degree of autonomy. This autonomy allowed them to dominate the policymaking process, which in the context of a

lack of commitment from the main parties, led to the introduction of a poorly specified bill that lacked commitment from the main political actors.

Before AUS

In the 2000s, Peru, like many countries in the region, had a fragmented health system. By 2007, those with formal jobs were part of the social security system through the Peruvian Health Social Insurance, EsSalud (20%), while the rest of the population either bought a private insurance (3%), affiliated to a special scheme for the poor (24.5%), or just remained unprotected (50.5%).⁷¹ This fragmented system was the product of a decade of market-oriented reforms that “epistemic communities” built between the Peruvian health bureaucracy and IFIs pushed for (Ewig 2010). Given the fragmentation and lack of resources of the sector, a reform that would bring more equity into the system had been a latent issue in the country. By the early 2000s, IFIs’ degree of interest and influence had decreased, and so did the autonomy of the technocrats linked to them (Dargent 2014). However an actor that gained importance during that time was USAID.

AUS had the goal of achieving, in the long-term, universal insurance coverage of the population, and gradually increasing coverage of health conditions by guaranteeing access to treatment for a set of diseases, and hence level the benefits across insurance schemes. The policymaking process of the health reform in Peru lacked the participation and commitment of the main political parties in the country. One of the main repercussions of this was that parties did not lead the agenda-setting process of the Peruvian reform; instead it was an actor outside the government that placed the issue into the political agenda, USAID.

Two programs created at the end of Alberto Fujimori’s second term (1995-2000) and implemented by the Ministry of Health (MINSA) formed the main precedents for AUS: 1) Free

⁷¹The remaining 2% was affiliated to the Military and Police Health System.

School Insurance (*Seguro Escolar Gratuito*, SEG) created in 1997 to give access to health services to children between 3 and 17 years old who were registered in public schools, and 2) Maternity and Child Insurance (*Seguro Materno Infantil*, SMI) created in 1998 for women going through pregnancy and post-partum as well as children below four years of age. These two programs included a very restrictive set of benefits for the most prevalent pathologies among the target populations. Although they were called “insurance”, those who were affiliated did not have to pay a premium, it was completely free. It was the first time the government had created schemes for people who did not have formal employment.

During the short interim government of Valentín Paniagua (November 2000-July 2001) after Fujimori’s fall, Health Minister Eduardo Pretell and his team, with the help of the PAHO, put together a proposal that would extend social security to citizens that were not part of the formal economy and hence did not have access to health services through EsSalud. The goal was to integrate MINSA’s provision system with EsSalud, which would involve EsSalud being transferred to MINSA.⁷² They proposed starting with a basic set of benefits that every Peruvian could have access to, although EsSalud affiliates would maintain their additional benefits.

However, the government of Alejandro Toledo (2001-2006) dismissed this proposal. Instead, in September 2001, they decided to integrate the two state insurance programs, SEG and SMI, into the new Comprehensive Health Insurance (*Seguro Integral de Salud*, SIS), maintaining a scheme of specific plans of benefits for each target population. Moreover, every child under 18 years old who was poor could have access to SIS. By 2005, every poor citizen could affiliate to SIS (See timeline at the end of the chapter).

The main problems SIS faced were related to its payment system based on refunds: MINSA refunded MINSA hospitals, the only place where SIS affiliates could get attention, only after

⁷²Since its creation, EsSalud had been under the Ministry of Labor.

they provided the services. However, these refunds took a long time and, in many cases, there were huge debts owed to the hospitals. As a consequence, in some hospitals, personnel started to make it very difficult for SIS patients to get attention as well as obstructing the process of affiliation to SIS.

Agenda-Setting

Political parties did not lead the agenda-setting process of the Peruvian reform. They lacked core ideological values uniting their members. Consequently, they lacked connection to the issue of healthcare reform (AUS). The positions of members of parliament representing the different parties, on whether an economy should be regulated by the state or the market are indicative of the parties' consensus on these values.

Table 5.1. Political Parties' Positions on a state-led versus market-led economy in Peru

Political Parties	State (1)	2	3	4	Market (5)	Standard Deviation
APRA	0	7.1	60.7	17.9	14.3	0.82
UN	7.1	7.1	21.4	42.9	21.4	1.11
UPP-PNP	17.1	17.1	48.6	5.7	11.4	1.15

Source: Parliamentary Elites in Latin America (PELA) 2006 study

As table 1 shows, there was a lot of dispersion within the different parties. In the case of the party in power, APRA, the importance of a market-led economy was not a core commitment of the party, although it was important for some of its members. The main value that has brought unity within APRA is the allegiance to its leader Alan García (and its founder Víctor Raúl Haya de la Torre), and not programmatic values. In the case of UPP-PNP, there was a lot of variation across party members regarding different values such as equality, social inclusion or a state-versus market-led economy. This electoral coalition, which managed to gather over 21% of the

popular vote and secure 45 of the 120 seats in the unicameral Congress, was not united by programmatic values but rather electoral prospects. The right-wing coalition UN, the third force in Congress, was also united for electoral reasons instead of around core programmatic values. By 2008, both coalitions had split.

In such a context, an outside actor, Partners for Health Reform*plus* (PHR*plus*), a five-year project (2000-2005) funded by USAID in Peru, was responsible for the introduction of AUS into the political agenda. In 2005, PHR*plus* convened representatives on the issue of health from all political parties. They produced the “Agreement of Political Parties on Health” and the continuation project of PHR*plus*, called Promoting Alliances and Strategies (PRAES), presented it to the public in January 2006. One of the main focuses of these meetings was the promotion of the universal health insurance (AUS) policy via a fragmented system, and so it was listed as a key priority in the final agreement. Nearly all the party representatives that participated in the meetings signed the agreement, with the exception of the left-wing UPP. According to its representative, it did not sign because AUS “*saw health as a commodity and not as a right.*”

PHR*plus* had worked on AUS since 2004, together with a plan of benefits and guarantees of health services to which those insured would have access. In an interview, a former PRAES member pointed out that it was important for the project “*to have a political consensus to back the AUS policy.*” A member of the USAID Health Office in Peru during that time noted that the agreement was important for USAID, as it was a highlighted point when asking for funds from their donors. AUS became a flagship project for USAID in Peru.

AUS would provide coverage to the 50% of the population that was uninsured, through the expansion of the healthcare scheme for the poor (SIS). SIS would expand in order to cover informal workers regardless of their income. Further, through PEAS (a package of benefits and

guarantees of health services), the coverage of those affiliated to SIS would gradually equate that provided by the social security system.⁷³ PEAS would be revised every two years.

Motivated by the discussions fostered by PHR*plus* and PRAES, between December 2006 and April 2007, seven bills were introduced to Congress.⁷⁴ Even though different parties introduced bills on the issue, these bills did not have their origins in debates within their parties. In the case of APRA and UN, the content of these bills was a product of a few advisors and consultants from the USAID project and the private sector.

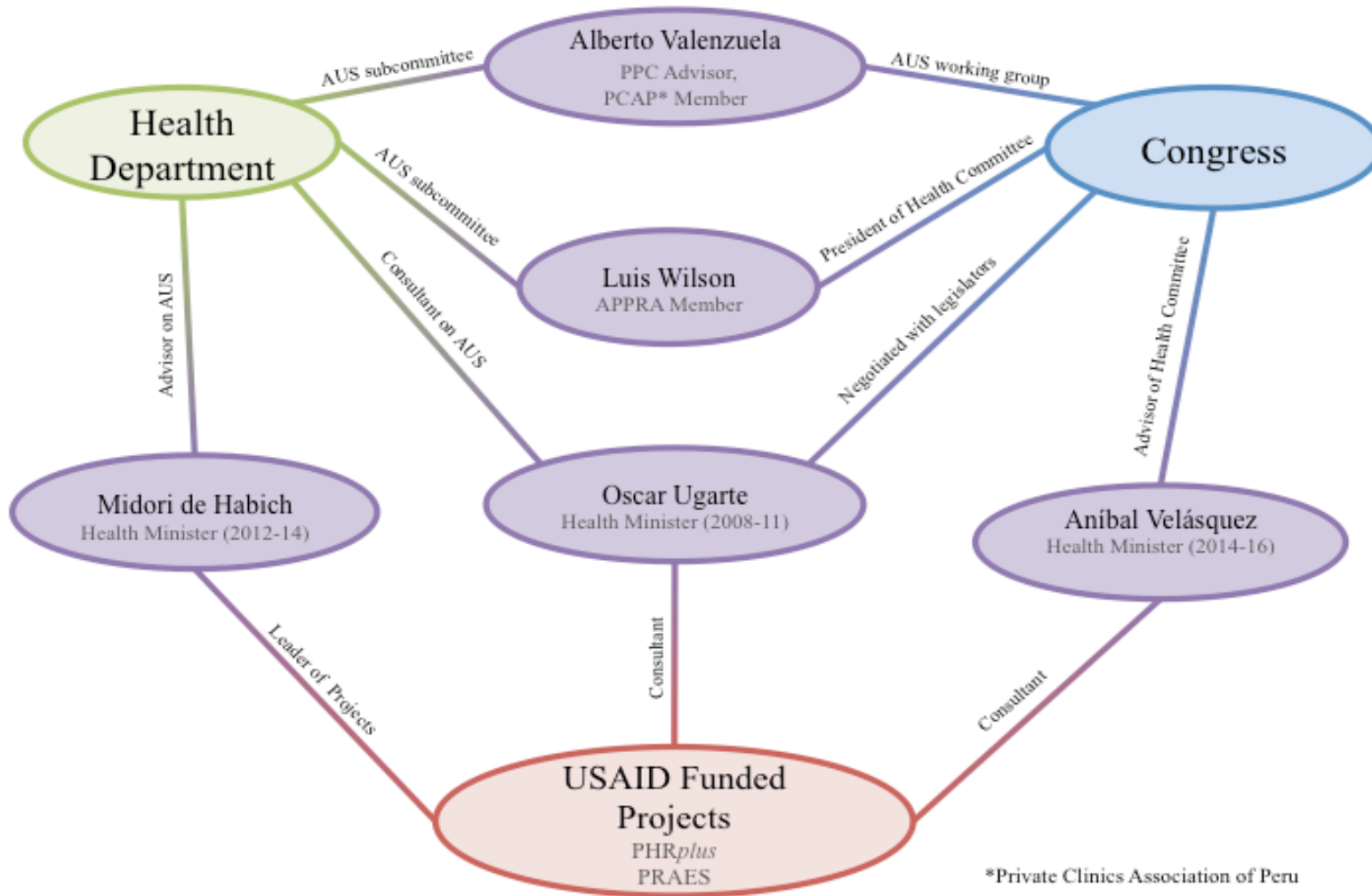
The first bill introduced to Congress came from the right-wing coalition UN. UN had two main advisors on health at the time: Jorge Ruiz, who was also CEO of an important private clinic in Lima (Stella Maris), as well as a board member of the Private Clinics Association of Peru (ACP, 2002-2012), and Alberto Valenzuela, who was the technical director of the same association. Both advisors noted that in 2005 they “*discussed some ideas with*” then leader of PRAES Midori de Habich (who later became health minister). Valenzuela also noted that they asked PRAES’ members for help in crafting the bill that they handed to the UN coalition in Congress.⁷⁵ A key member of PRAES, Oscar Ugarte (who also became health minister), noted: “*AUS was proposed by PRAES and then taken by UN and APRA.*” De Habich, however, stated she did not remember whether the bill for UN was crafted within PRAES, although “*it is possible that PRAES had put together a draft of AUS and shared it with all the participants*” as it was a rule of the group to not help a specific party. Figure 1 shows a graphical depiction of the connections between the different actors involved in the policymaking process of AUS.

⁷³The set of benefits that social security affiliates enjoyed was much more substantial than that of SIS’ affiliates.

⁷⁴In Peru, political parties as well as individual legislators can send bills to Congress. A political party can send a bill indicating the initiative of a specific legislator.

⁷⁵It was also the job of this second advisor to gather the signatures of all the coalition members on the bill before it was introduced.

Figure 5.1. Main Actors and Connections of the Policymaking Process of AUS in Peru



The right-wing APRA, the party in government, also introduced a bill, which proposed a package that would establish the benefits and guarantees of health services that all insurance institutions, public and private, would be bound to fulfill (called PEAS). PRAES members as well as MINSA officials stated in my interviews that PEAS was a product of the USAID funded project, which had worked on it since 2004. A month later, APRA introduced a second bill, which was very similar to UN's bill. The main APRA advisor on health issues claimed that it was due to a dialogue that existed with UN advisors, who became of "*great technical and political support*".

The opposition also introduced bills on the issue. The main advisor of the left-wing coalition UPP-PNP, who was also the only representative that did not sign the USAID agreement back in 2005, had an important role crafting their first bill. He noted that the proposal was unviable given the skeptical position most congressmen had towards a universal social security system that would put an end to the fragmented system. Indeed, the idea of merging the social security system (EsSalud) with the insurance system for the poor (SIS) was highly controversial, as its opponents argued that EsSalud would not accept its contributions being used to subsidize services for anybody else. The party decided to send the bill, even though they knew it had no chance of going forward. Just a month later, another congresswoman sent a new bill, although, as one of the health advisors of the coalition noted, without prior discussion and hence without the support of the coalition members. The third bill from the left-wing coalition "*jumped into the AUS boat*" (in the words of the main health advisor of the coalition), as it understood their original idea was not going to get anywhere.

Then president of the Health Committee (HC) in Congress, Luis Wilson (APRA), formed a

working group on AUS in July 2008. The health advisors of the different parties participated, as well as PRAES members Aníbal Velásquez (who also became health minister) and Oscar Ugarte. Wilson's main advisor noted that Wilson asked for help from PRAES and that "*PRAES already had an outline of how AUS should look.*" The HC discussed AUS for the first time in September 2008.

The evidence is that members of the USAID projects had been working on AUS since 2004, before the bills were presented to Congress in 2006. They had meetings with representatives of parties and their experts heavily influenced the AUS bills UN and APRA introduced. Within USAID, AUS was regarded as a major success as they decided important details of the reform. They successfully prevented the expansion of social security and instead pushed for the continuation of a fragmented system. Moreover, three of their consultants went on to become health ministers: Oscar Ugarte (2008-2011), Midori de Habich (2012-2014), and Aníbal Velásquez (2014-2016). In the context of non-programmatic parties, external actors are determinant to the introduction of reforms into the agenda.

It is important to note the participation of the private provision sector during this stage of the policymaking process. UN advisor Jorge Ruiz, representative of the Private Clinics Association of Peru, was in charge of crafting the bill UN introduced in Congress. This bill proposed a system that maintained the independence of the private sector and secured that no harm would come to the sector. Together with the USAID projects, the private sector was able to prevent a unified system that could limit its importance.

Political parties did not lead the agenda-setting process of the Peruvian reform. The parties lacked core ideological values uniting their members. Consequently, they lacked connection to the prospect of healthcare reform. Although different parties introduced bills on the issue, in the

case of APRA and UN, a few actors from USAID and the private sector crafted these bills. The leftist coalition UPP-PNP initially introduced a bill opposing AUS and favoring the expansion of social security. However, they later supported the continuation of the fragmented system via AUS. In the context of non-programmatic parties lacking commitment to the reform, an external actor in the form of the USAID funded projects was determinant to the introduction of the reform into the agenda.

Debate

The process of debate of AUS in Peru lacked the participation of the main political parties. The Peruvian parties lacked core values that could connect to the issue of healthcare reform and therefore had no programmatic commitment to the reform. The Peruvian parties did not shape the specifications of the policy and approved a law that lacked specifications regarding the necessary funding to be implemented. AUS promoters preferred to avoid discussions on infrastructure and funding because these issues were considered controversial and could put at risk the passage of the law. Individual technocrats filled the void that the lack of participation of the parties left.

In September 2008, the HC in Congress discussed AUS for the first time. The right-wing coalition UN introduced one of the first bills (and the final law Congress passed was very similar to this bill). However, as the transcriptions of the debates show, their representatives in Congress rarely participated in the debates within the HC and on the floor. As UN advisors Ruiz and Valenzuela, who were also private sector representatives, commented in my interviews, they had to gather the support of the UN legislators.

The opposition UPP-PNP sent the first bill that proposed an alternative to the fragmented system, advocating for the universalization of social security. However, they later sent a new bill

supporting AUS, with the caveat that it was considered an intermediate stage in the process of building a universal social security system. For APRA and UN members, this left-wing opposition promoted a utopian discourse of “*everything for everybody*”. UPP-PNP failed to push for better policy specifications during the debate and in the end UPP traded its vote. UPP congressmen were not interested in passing a proposal that could be implemented. As a UPP advisor put it, it was a clear indication of the party’s lack of maturation and the main reason why they were not strong enough to oppose AUS in Congress. In my interviews, the main advisors from APRA, UN, UPP and PNP noted that most congressmen, as well as their staff, lacked health policy expertise and did not understand the projects that well. This is symptomatic of the lack of connection that the healthcare reform had to the core values of these parties.

At the HC, two main advisors were in charge of the AUS working group; one of them was Aníbal Velásquez, from the USAID funded project PRAES. They were also in charge of meetings with all the other actors that participated in the debate. Then president of the HC, Wilson (APRA) noted that the point of these meetings was to generate consensus between the different actors involved. However, those who represented the opposition to AUS disagreed and argued that the meetings were mainly to convince them, that “*they were monologues of PRAES people... they were not debates but presentations.*”

After holding nine hearings between September and December 2008, the HC gave its opinion (*dictamen*) on AUS. During the HC meetings, the funding of AUS failed to become the center of discussion. AUS was going to require a good amount of funding for two main areas: strengthening the supply side (mainly infrastructure and human resources) and financing the demand (the state would cover the services for poor people completely and partially for those

with some acquisitive power). Surprisingly, not much debate went into how to fund this ambitious proposal.

In the Executive, the issue of funding did gather more attention. According to then Health Vice-minister's advisor, who was in charge of the meetings between MINSA and the Ministry of Economy and Finance (MEF), "*the main question MEF had was how are you going to do this? But that had not yet been designed. We [MEF] wanted concrete numbers... There was no financing plan.*" The advisor also noted that the agreement they reached was that "*MINSA would make do with what they were given.*" Both the vice-minister and minister of health at the time concurred that they settled for this agreement and expected to get money in the future.

If the AUS bill did not specify the amount of monetary resources needed, neither did it specify the sources. The bill only mentioned that the funds would come from general taxes and APRA legislators emphasized that the Executive would be in charge of determining the details once AUS was approved. Moreover, several AUS promoters emphasized that engaging in a discussion about funding and its sources was going to put at risk the passage of the law. In my interviews, the former health ministers as well as the UN and APRA legislators that promoted AUS noted that the context of consensus that was achieved had to be used to launch AUS, even though that meant not having secure funding.

This situation did not go unnoticed. One argument used to criticize AUS during the debate in Congress was that it did not include the sources of funding for the reform, and hence it would not be sustainable over time. During a presentation at a HC session, the president of the National Association of MINSA Doctors emphasized that "*there cannot be any significant and substantive change without policies made to resolve the situation of human resources.*" He also stated that health policies in Peru should not be "*mere demagogic actions that lead nowhere.*"

An issue that did gather more attention was the role of the private sector. The opposition to AUS claimed that the reform was going to privatize the health system by bringing more business to the private sector. Private providers saw themselves being highly benefited by AUS through the sale of health services to the public sector. The Private Clinics Association of Peru did not send a representative to the HC, but they already had two of their members as key actors in the process since its origins: Ruiz, board member of the association and CEO of one of the most important clinics in Lima, as well as Valenzuela, technical director of the association, who were also UN advisors.

The Peruvian Association of Insurance Companies did send a formal letter to the HC but only at the end of the process, when the committee had already stated its opinion. They asked to participate in the National Health Superintendency (SUNASA), the entity that would be in charge of monitoring the implementation of AUS. Then technical director of the association noted that a concern for them was that the plans that private insurances already offered would not necessarily consider all the health conditions and benefits established in the reform.⁷⁶

Exactly six days after the HC in Congress gave its opinion, the Executive sent a bill to Congress. It was nearly identical to the HC's opinion. According to then Health Minister Ugarte, this bill was made in dialogue with some legislators' advisors as well as with PRAES leader de Habich. The president of the HC, Wilson (APRA), noted that it was important that the Executive sent this bill to show its political support to the project.⁷⁷ Only two points differentiated this bill to the committee's opinion: 1) it gave SUNASA sanctioning powers and 2) it stated that MINSA would establish an implementing body during the first two years after the passage of the bill.

Congress voted on AUS in March 2009. The law passed with 59 votes in favor; surprisingly,

⁷⁶For instance, including some psychiatric services was a concern, as neither private clinics nor public hospitals could provide the required services.

⁷⁷President García started referring to AUS in public as one of the main promises of his government.

14 of those votes came from left-wing party UPP, one of the parties that had opposed AUS. The health minister at the time noted that “*there was a political convincing of UPP.*” Then advisor to UPP leader Francisco Escudero explained that Congressman Wilson and the health minister convinced Escudero of the positive sides of AUS. Wilson’s advisor’s account varies from this. He noted that they agreed with Escudero on UPP voting in favor of AUS and then APRA would vote in favor of a law Escudero had been trying to pass for a while. This was not a bad offer as APRA had the larger number of seats in Congress (after PNP and UPP split).⁷⁸ Right after AUS passed, the discussion of Escudero’s bill was included in the HC agenda “with priority” and approved some months later with the votes of all APRA legislators.

The process of debate of AUS was not very open. As member of the HC Walter Menchola (UN) commented, “*the script was already written, there was not much to discuss.*” If we go over the policymaking process of AUS, from agenda-setting to debate, there was a very limited group of people participating, who rotated among MINSA, the USAID funded projects, and the private sector. The evidence shows that there was no real commitment to make the debate process a participatory one. An excerpt of my conversation with the main HC advisor at that time might be indicative of the process: “*I have to admit that I was a little bit of a dictator... ‘Do you like it [a part of the AUS bill]? No? I will include it anyways.’ Otherwise, it did not move forward.*”

Given the lack of core values of the Peruvian parties present during the debate on AUS, the parties lacked connection to the policy and did not attempt to shape the specifications of the reform. This defined both the process of debate as well as the content of the law. Approved in 2009, the law was highly similar to the first bill UN introduced in 2006. The parties in Congress were not part of an exhaustive process of debate. Instead, its members tried to avoid the discussion of many important issues such as funding, the feasibility of the project given the

⁷⁸PNP remained firm in their position that AUS was only going to benefit the private sector and voted against it.

shortage of human resources and infrastructure, as well as its sustainability. This lack of commitment of the most relevant political actors proved to be costly during implementation.

Technocrats filled the void that the lack of participation of the parties left in Peru, becoming the protagonists of the process of debate of AUS. A key technocrat during the AUS debate was former PRAES consultant and then Health Minister Oscar Ugarte. Even though the issue of reform was already on the agenda before he became head of MINSA, the process of debate accelerated with his arrival and he acted as mediator between Executive and Legislative. PRAES provided logistical resources throughout the process of debate. They not only sent a consultant (Aníbal Velásquez) to the HC in Congress, but also organized meetings outside Congress. As confirmed by the leader of the USAID funded project, de Habich, they were in charge of *“synthesizing differences and similarities [of the bills] at the request of Wilson, president of the committee. This work led to the opinion adopted by this committee.”*

These technocrats did not have ties to the political parties in charge of the reform's debate. Given the short-term nature of their influence, these technocrats did not commit to crafting a bill with clear specifications regarding the funding and infrastructure needs for the reform to be implemented. When asked about this lack of key specifications, different technocrats noted that they were unnecessary at that point. Moreover, that the next government should be in charge of crafting them, and that it was easier not to include them.

A Congress formed by non-programmatic parties approved a law that lacked the necessary funding to be implemented. AUS promoters preferred to avoid discussions on infrastructure and funding that could put at risk the passage of the law. As the main HC advisor put it, this followed *“the norm that ‘big policies’ are not approved in Congress, but ‘small’ ones that are easy to understand”*. As we will see in the next section of the paper, this process came with a high cost.

Implementation

The implementation of the Peruvian health reform increased the amount of people with formal insurance coverage. Whereas 49% of the population was insured in 2007, 73% had insurance in 2016. We must be cautious, however, in considering an increase in formal coverage an indicator of success of the reform since the constraints to effective access of people covered “on paper” have gotten in the way. Increased formal coverage was accompanied by a shortage of the required resources (infrastructure and human resources) to provide services. Moreover, the reform fostered an increase in state funding for health, but this funding has been inconsistent. The budget saw a reduction of almost 3% for 2016 and of 15% for 2017. The lack of commitment to the policy from non-programmatic political parties in Peru led to a poorly specified legislation and a deficient implementation, ultimately contributing to the shortage in effective access to healthcare for the population.

AUS passed a vote in Congress in March 2009. A special commission within MINSA, aided by the USAID funded project PRAES, crafted the National Implementation Plan in January 2009. There was a set of benefits and guarantees of health services that all health insurance institutions (public and private) would be bound to fulfill (called PEAS). PEAS considered 140 illnesses for which timely and quality service had to be guaranteed, and it would be revised every two years.

When asked about how ambitious the package was, given the shortage of infrastructure and human resources in the public system, the PRAES member in charge of the PEAS design argued that infrastructure could be strengthened later and that *“to pose that a plan should exist after the [infrastructure] conditions exist delays the process.”* Indeed, MINSA began implementing AUS in some areas of Peru without the infrastructure and human resources necessary. The Implementation Plan established that AUS would start in 7 strategic areas (pilots, which had

between 54% and 84% poverty). They started in December 2009 and had to guarantee treatment for 34 illnesses. Another USAID funded project called HS2020 was in charge of the implementation of PEAS in these pilots. At the beginning of 2010, Lima and Callao were included as pilot areas of AUS, even though they did not fulfill the condition of having a large poor population. According to then health vice-minister, an APRA member close to President García, García decided that these two regions had to be included “*otherwise nobody was going to see the results of AUS.*” The shortage of infrastructure and human resources, which was not tackled before starting the pilots, was a major problem.

During the debate of AUS, congressmen from non-programmatic parties who were disengaged from the process and technocrats from the USAID funded projects and the private sector avoided a discussion regarding infrastructure. Plans to strengthen the infrastructure of hospitals and health centers, overcome the shortage of doctors, nurses and other health personnel never emerged. How to fund the reform was never part of the debate either. These policy specifications were necessary for AUS to become a reality not just in terms of formal insurance coverage, but also in terms of actual delivery of healthcare services.

President García’s term ended in 2011 with a mediocre implementation of AUS in the pilot regions. Lack of infrastructure and shortage of human resources got in the way, problems that could not be solved without a necessary injection of funding. The process of debate of AUS produced a law that lacked the necessary funding for implementation. During the first three years of the reform, the funding assigned to the public healthcare scheme covering those outside the social security system did not see significant changes, as shown in table 2. The budget has even seen reductions since 2014, of up to 15% for 2017. AUS is a policy without the necessary funding.

Table 5.2. Formal Public Insurance Coverage and Public Budget in Peru

	Insured Population (%)	Budget (Million PE Soles)
2007	24.5	268
2008	36	471
2009	40.6	430
2010	42	464
2011	42.8	569
2012	37.7	585
2013	45	925
2014	51.1	1,392
2015	53.8	1,705
2016	54.3	1,658
2017	55.0	1,410

Source: Data from the Ministry of Health (MINSA)

President Ollanta Humala (2011-2016) was the leader of the only party (PNP) that voted against AUS. In July 2012, Midori de Habich, former leader of the USAID funded projects, who had been actively involved in the agenda-setting and debate of AUS became health minister. MINSA started the implementation of AUS across the whole country.⁷⁹ One of the first steps was implementing a prospective type of payment for the services delivered to the affiliates. By the end of 2012, SIS, the financial institution in charge, was making trimestral monetary transfers to the hospitals and health centers before they provided services. As table 2 shows, an important

⁷⁹According to former Health Minister Ugarte and other interviewees, de Habich convinced First Lady Nadine Heredia of the importance of continuing with AUS. Heredia was a powerful actor during Humala's government.

injection of funding for the health sector arrived: whereas the budget from 2008 to 2012 was between 400 and 500 million soles, it was 900 million (around 300 million USD) by 2013.

The increase of funding was not the only important change, but a MINSA team, composed of previous PRAES members, prepared a group of 23 laws that had the goal of making AUS possible. Instead of sending the bills to Congress, the Executive decided to ask for legislative powers and passed the laws through legislative decrees. Between September and December 2013, the Executive enacted the 23 legislative decrees.

Three main decrees attempted to tackle the shortage of human resources and infrastructure of MINSA facilities. One of them tried to make the wages of doctors homogeneous across the country, as well as giving an incentive to doctors that had to work in remote and border areas through a bonus system. Another decree endeavored to make the investment in infrastructure a more expedited process, together with the project of building 11 new national hospitals, 23 regional and 170 provincial. A third decree proposed the exchange of services between the public health system and EsSalud as well as purchasing services from the private sector. Some exchange of services between the public health system and EsSalud has started to take place, although the payment for those services has been slow. The main problem with hiring private services has been that some services are overvalued, in which case SIS ends up paying more for a service in a private clinic than a private insurer would pay. Another problem is the lack of regulations for emergency care of public sector affiliates in private clinics.⁸⁰ The sustainability of this process is a concern: if the purchase of private services was posed in order to decongest the public sector because its offer was insufficient, the question is until when and to what extent will they continue to acquire private services. The worry is for it to become a long-term solution, which would become financially unbearable.

⁸⁰See Arrieta 2012 on over diagnosis of affiliates.

As table 3 shows, the increase in hospital beds in the public sector was not very rapid. The rate at which infrastructure was growing did not meet the large increase in formal insurance coverage: 15% of the population (almost 5 million Peruvians) affiliated between 2009 and 2015.

Table 5.3. Infrastructure in the Public Health Sector in Peru

	Hospital Beds	Beds (per 1,000 people)*
2004	23,889	1.5
2005	24,055	1.5
2006	24,171	1.6
2007	25,389	1.6
2008	25,337	1.6
2009	25,607	1.5
2010	25,580	1.5
2011	25,969	1.5
2012	26,145	1.5
2013	26,700	1.5
2014	27,970	1.6
2015	28,012	1.6

Source: Data from the Ministry of Health (MINSA)

* Includes beds in private clinics

AUS was a reform that did not specify its funding neither how to overcome the infrastructure gap the public system had in order to expand access to healthcare. Given the lack of policy specifications, the progress of the reform was very slow. AUS only began to move forward when one of the USAID technocrats who had been involved since agenda-setting, de

Habich, became health minister. Her arrival led to an increase in funding as well as a set of decrees designed to help with the shortage of infrastructure. Even then, as members of the MINSA team then in charge of the implementation of AUS commented, one of their main challenges was the instability of funding. For the former health minister, the funding was at risk because it depended on “*the ability of MINSA to negotiate with MEF, which has always been weak*”. As she pointed out, this was fortunately not an issue in her case.⁸¹

The revision of PEAS every two years never happened.⁸² Most public health facilities were not able to provide PEAS due to their lack of infrastructure and human resources. In that context, revising a plan that was impossible to fulfill did not make much sense. The conditions PEAS included were unrealistic, for instance, in terms of the time that the personnel should take to provide a certain service or the exact number of tests that they should apply to a patient.

In the case of the private sector, PEAS was simply irrelevant. Private insurers sell two types of insurance schemes: plans for those with formal jobs who would rather get attention in the network of private clinics (EPS), and plans for specific coverage (i.e. cancer). The inclusion of PEAS for the first type of plan was not a problem as, like in the case of EsSalud, its benefit plan was already extensive. They just had to add the coverage for some additional interventions and, as former executive of Pacífico Seguros -one of the biggest insurance companies in Peru- noted, they did so economically. The problem was with the specific-coverage plans, as it was impossible for these plans to include PEAS. Therefore, the enforcement of PEAS never happened in this case. For former Health Minister de Habich, “*it is best to ignore the part of the law that talks about PEAS and the private sector.*”

⁸¹Members of both MINSA and MEF noted that de Habich was able to convince the minister of economy and his team due to the fact that she was an economist herself. She had studied in the same university where most MEF members did and had previously worked for the Peruvian Central Reserve Bank.

⁸²The entity in charge of providing technical assistance for this revision was the USAID funded project PolSalud, the continuation of PRAES.

PEAS was envisioned as the technical tool that would make AUS more tangible, providing users with a set of benefits they had the right to in both the public and private sectors. As de Habich commented, PEAS was important because it would allow citizens to hold the system accountable. However, when asked about the current situation, where PEAS does not mean much for citizens since access is highly limited in many places, she noted that PEAS “*stated where we should move towards. As a policy tool, it is what you want to happen... an instrument of what should be.*” Moreover, she agreed that PEAS could not be revised as not even the original plan can be provided.

By 2017, more than 17 million Peruvians (over 55% of the population) were affiliated to the government’s free insurance scheme (24.5% were affiliated when the reform was conceived). While the number of affiliates grows, so do the complaints regarding the capacity of the public system to respond to this enormous demand. In theory, this public insurance could cover everything today, as affiliates can also access a Complementary Plan to cover any other health intervention up to 7,900 soles (2,600 USD) and Extraordinary Coverage in case the cost for these extra interventions surpasses this sum. The former SIS Chief noted that they were spending a third of their budget on this and that was precisely why they “*did not want them [the affiliates] to know.*”

40% of SIS affiliates are in rural areas of Peru, precisely where access is more limited. When the required technology or personnel is not available in a facility, patients can be referred to the nearest facility able to cover the need. In the majority of cases, these patients do not go to the referred facility. According to official MINSA data, by 2016, only 0.5% of referred patients accessed the required care. The main reason is that patients cannot afford transport to a different facility.

Despite its shortcomings, AUS has brought more organization to the chaotic system of public provision. The reform also led to the creation of the National Health Superintendency (called SUSALUD since 2014), in charge of protecting the rights of all users of health services by monitoring health facilities and insurance entities (both public and private).⁸³ Moreover, AUS brought the possibility of increasing funding for the sector, which more than doubled between 2012 and 2014. The main concern of MINSA officials is the stability of the funding since they have seen significant reductions in the past three years. There is uncertainty with regards to how much money MEF will give year by year. Many experts concur that the best way to give stability to the funding is to calculate a premium that could become the base for the assignment of funding, then funding would increase as the number of affiliates increases.⁸⁴

The policymaking process of AUS in Peru shows that when a policy reform is approved without enough planning behind it, the reform's sustainability depends on short-term factors such as the presence of individual actors. The implementation of AUS only progressed when the former leader of the USAID projects became health minister. A policy designed by technocrats still needed to be carried by committed politicians during its implementation to succeed. However, there has been no political commitment to the healthcare reform. One of the main signs of this is the inconsistent funding the reform has suffered. Given the shortage of infrastructure and human resources, most public health facilities are not able to provide the promised interventions and benefits. As a health official noted, Peruvians are given “*a right limited to budget availability*”.

⁸³So far, they have two offices (Lima and Chiclayo). The projection is to open one in each region.

⁸⁴This is hard because there is a lot of “filtration” in the system (people who do not qualify are included). SIS calculates this is between 10% and 30% of affiliates. If the budget were to be assigned based on a premium, SIS would be forced to verify its pool of affiliates.

Conclusion

Political parties without core values, who did not have any commitment to healthcare allowed the policymaking process of the reform in Peru to be led by technocrats from the USAID funded projects. Partners for Health Reform *plus* (PHR *plus*), a five-year project (2000-2005) funded by USAID introduced the AUS reform into the political agenda, with the collaboration of private sector representatives. The need for policy that would expand access to healthcare to excluded populations was slowly penetrating the agenda of Latin American countries. International organizations such as the World Bank, the WHO and the PAHO started to advocate for such expansion since the early 2000s. Moreover, the PAHO actually cooperated with the interim Peruvian government in 2001 to put together a proposal to extend social security to informal workers. While political parties were not interested in the healthcare issue, the USAID project took the initiative of designing a reform that, while extending access for many people, would maintain the fragmented system and leave the interests of the private provision and insurance sectors untouched.

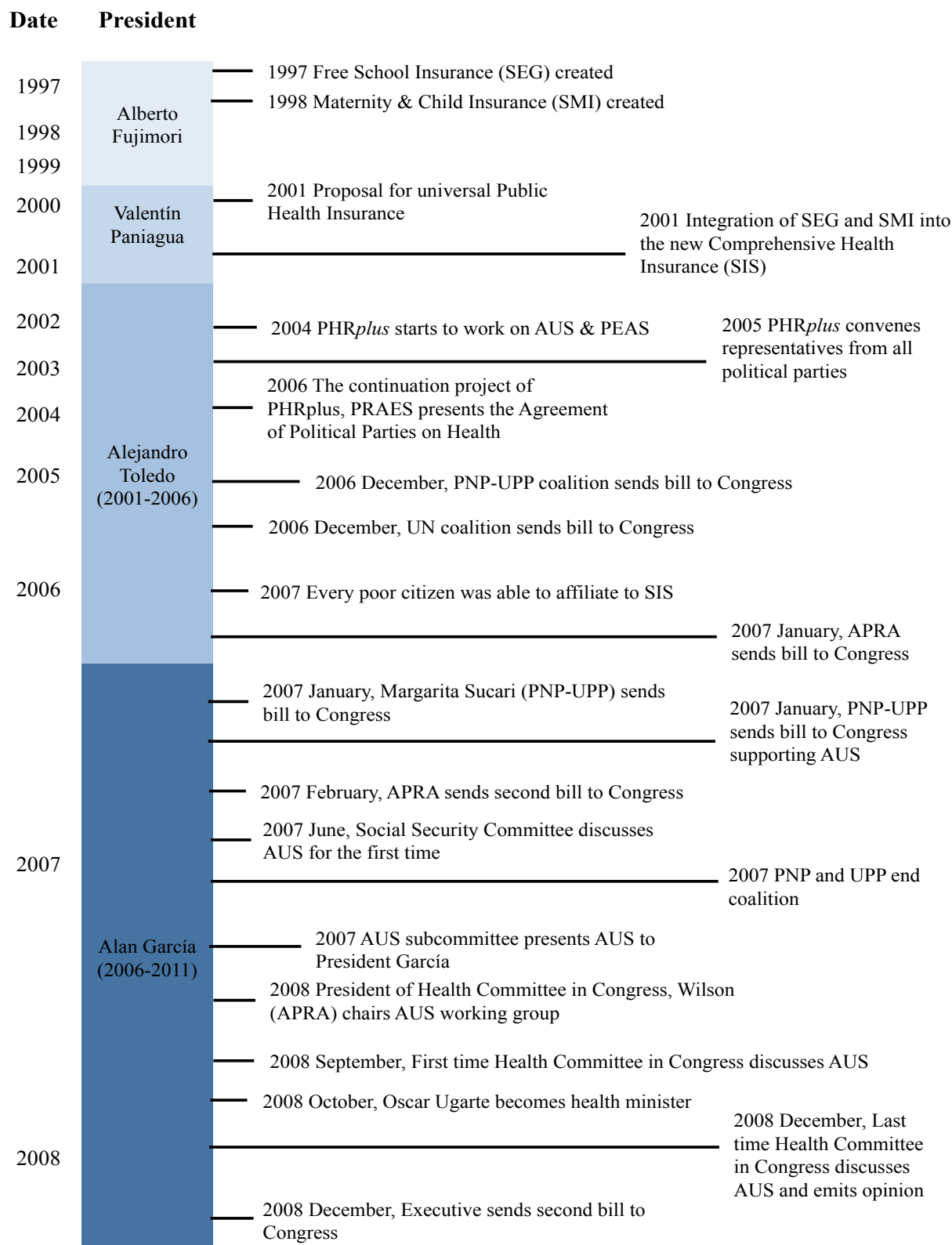
During debate, the main parties in Peru did not care to specify the necessary funding and infrastructure provisions for the reform. Technocrats without partisan ties dominated the process, crafting a poorly specified policy as they considered that provisions regarding funding and infrastructure were unnecessary before the implementation stage and could risk the passage of the bill. The implementation of the Peruvian reform has been contingent on short-term factors such as the presence of individual actors, and there is no stability in terms of funding. Due to a lack of funding and infrastructure gap in the public sector, the AUS reform moved slowly during its first years. When one of the USAID technocrats who had been involved since agenda-setting became health minister in 2012, the funds destined to the reform increased. However, a key challenge is the instability of funding. The promoters of AUS, in a context of politicians lacking

programmatic commitment to the reform, did not provide a feasible or sustainable solution to the problems Peru faced regarding access to healthcare.

The Peruvian case demonstrates that in the context of parties without commitment to healthcare reform, technocrats who lack incentives to provide clearly defined policy options can dominate the policymaking process. The lack of commitment from the main political parties in the reform processes has as its main repercussion a poorly specified legislation and deficient implementation, and ultimately lower welfare for people. A policy designed by technocrats still needs political commitment during its implementation to succeed.

The reform sought to tackle a system that discriminated based on the socioeconomic status of their citizens. Whereas more Peruvians enjoy formal coverage thanks to AUS, the shortage of means to effectively provide such coverage gets in the way. This context generates a type of discrimination based on the availability of services: if you live in a place where there are resources to provide services, you could indeed get financially covered for a large set of interventions; if not, you are covered only in theory.

Figure 5.2. Timeline of the Policymaking Process of AUS in Peru



Date	President	
	Alan García (2006-2011)	2009 January, PRAES crafts National Implementation Plan of AUS
2008		2009 March, First floor debate on AUS
		2009 March, Second floor debate, AUS law is approved
		2009 April, AUS law is enacted
		2009 June, Implementing body CTIN's first meeting
2009		2009 November, Executive Decree approves PEAS
	Ollanta Humala (2011-2016)	2009 December, Implementation of AUS begins in pilot regions
		2010 January, CTIN approves regulations of AUS
2010		2010 January, Lima and Callao become pilot regions of AUS
2011		2011 July Law of Public Financing of AUS is approved
2012		2012 July, Midori de Habich becomes health minister
2013		2013 January, SIS budgets increase by 100% (1 billion soles)
		2013 September-December, Executive enacts the 23 legislative decrees
		2014 National Health Superintendence becomes SUSALUD
2014		2014 Pregnant women & children under 5 able to affiliate to SIS
		2014 November, Aníbal Velásquez becomes health minister
2015		2015 Over 50% of the population outside the social security system is insured
2016		2016 USAID Health Office closes

CHAPTER 6: TWO PATHS TO REFORM: POLITICAL PARTIES AND TECHNOCRATS IN LATIN AMERICAN HEALTHCARE POLICY

Programmatic parties have core values that unite their leaders and drive the party program.

Whereas certain policy issues are directly related to the core values of a party, others are not.

This chapter shows that having programmatic parties is not sufficient to explain the participation and impact of parties in policymaking, but what determines this participation and impact is whether a specific policy relates to the core values of parties and thus generates a **programmatic commitment** to the policy in question.

The programmatic commitments of parties affect the quality of legislation and its implementation. These commitments shape the specifications of a reform regarding implementation and funding. The programmatic participation of political actors in the definition of specifications forges a commitment of these same actors to implementing the reform, which determines its feasibility and sustainability. The chapter shows how when parties lack core values or such values do not relate to the policy, legislation may still pass but technocrats without partisan ties dominate the process. Given the lack of commitment from the main political actors, this leads to a policy that is poorly designed for effective implementation.

Reforms seeking to expand access to healthcare can follow a *partisan path*, in which parties with values closely tied to the policy issue play a central role in defining the specifications of the reform. Reforms can also follow a *non-partisan path*, in which parties disengaged from the definition of specifications of a reform allow technocrats without partisan ties to dominate the

polymaking process. Both paths can lead to reforms that increase coverage and even increased funding for the health sector. The key difference is in the feasibility of ensuring access to healthcare and the sustainability of funding.

Agenda-setting

Since the return to democracy, in 1990 in Chile and in 2000 in Peru and Mexico, reform of the health sector has been a latent issue due to the fragmentation of the systems and the lack of resources. In the early 2000s, Chile, like many countries in the region, had a fragmented health system with the National Health Fund (FONASA) covering those with formal jobs and the poor (70%), *Instituciones de Salud Previsional* (Isapres) offering alternative private insurance (21%), and a small segment of people without any type of insurance (9%). In Mexico, the population without any coverage was much larger (54%), whereas the Social Security Institute (IMSS) and the Institute for Social Security and Services for State Workers (ISSSTE) were covering those with formal jobs (44%) and only a small minority had a private insurance (2%). By 2007, the Peruvian Health Social Insurance (EsSalud) covered those with formal jobs (20%), while the rest of the population bought a private insurance (3%), affiliated to a special scheme for the poor (24.5%), or just remained unprotected (50.5%).⁸⁵

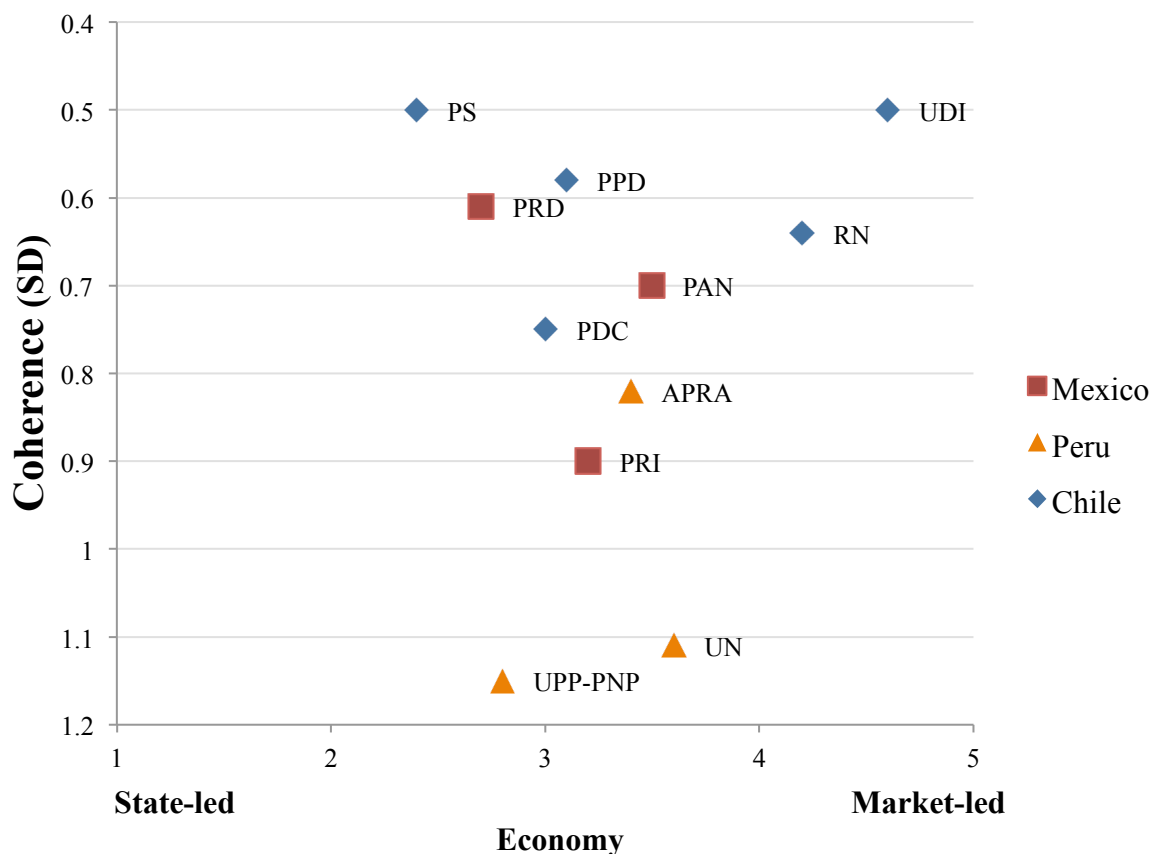
The health reforms introduced in the 2000s in these countries shared two main long-term goals: 1) expansion of insurance coverage of the population, which was particularly important in the cases of Mexico and Peru, and 2) gradually increasing coverage of health conditions by guaranteeing access to treatment for a set of diseases, and hence level the benefits across schemes. The reform process in the three countries was very different with regard to the involvement of parties, as was the quality of the legislation produced. In Chile, political parties

⁸⁵The remaining 2% was affiliated to the Military and Police Health System.

were closely involved at all stages of the process, as the reform connected with their core values; in Mexico, PAN, a programmatic party, was marginally involved because the reform was not related to its core values; and in Peru parties did not have core values that united them and thus were not involved. As a result, in Mexico and Peru, technocrats rather than parties placed the issue into the agenda and there was a lack of commitment from the main parties to the reforms.

The positions of members of parliament representing the different parties, on whether an economy should be regulated by the state or the market are indicative of the parties' consensus on these values.

Figure 6.1. Coherence: Parties' Positions on a State-led (1) versus Market-led (5) Economy



Source: Parliamentary Elites in Latin America (PELA): Chile (2002), Mexico (2001), Peru (2006)

As figure 1 shows, there is more cohesion among the Chilean parties, in comparison to their

counterparts in Mexico and especially Peru. The least coherent party in Chile, PDC, is still more coherent than the most coherent party in Peru, APRA. Chilean parties are coherent on the role of the state, not just regarding the regulation of the economy but also in the provision of social benefits. Whereas the survey of members of parliament did not ask about social benefits, evidence from interviews with politicians suggests that they also cohere on the role of the state in providing social benefits (Pribble 2013).

We can observe a lot more disagreement within Peruvian parties, which lack core values in general (Cameron 2011, Kitschelt et al. 2010, Levitsky 2013, Levitsky 2018, Levitsky & Cameron 2003, Tanaka 2005). There is more variation in the case of Mexico, with PRD being more coherent than PRI and PAN. The ruling party, PAN, although not as coherent on the role of the state as the Chilean parties, did hold a core value uniting its leaders. At the core of PAN's ideology was Catholicism (Hawkins et al. 2010, Magaloni & Moreno 2003).

There are key distinctions across the agenda-setting processes of the three reforms. The Chilean reform was born through the programmatic commitments of the center-left coalition, Concertación. Although there was no agreement on the details of the reform, the parties discussed its necessity in order to bring more equity to the health system. The health reform was placed on the agenda in 1999, during the presidential campaign of Concertación's leader, Ricardo Lagos (PS). Concertación's government program made health reform a priority, pointing out the inequities of a system where financial resources determined access to health. As members of Concertación Enrique Accorsi (PPD) and Soledad Barría (PS) noted, the inclusion of health reform as a priority in the program had been discussed with the different parties that formed the leftist coalition. However, there had been no discussion regarding the details of the reform.

The Health Department (MINSAL) submitted the AUGE bill to Congress in May 2002.

AUGE had the goal of giving patients across systems (private and public) rights and guarantees for a prioritized set of health interventions, and thus achieve equity across systems. In June, they sent the Financing Law bill, which would establish the financial resources for the reform.⁸⁶ During the agenda-setting process, the Chilean parties that were part of the Concertación coalition were committed to the introduction of the healthcare reform into the agenda.

In the case of Mexico, the right-wing PAN in government, had a key core value uniting its members: Catholicism. However the health reform was tangential to this core value. Consequently, PAN did not introduce the issue into the agenda nor shaped the specifications of the reform but only supported it under the command President Vicente Fox. Members of the Health Secretariat as well as of PAN agree that there was no participation of the party. Health Secretary Julio Frenk introduced the health reform proposal into the political agenda in 2000. Frenk, who had no partisan affiliation, had worked on this proposal since the early 1990s for Funsalud, a think tank financed by the health business sector.

SP would provide protection to those without insurance (known as the “open population” in Mexico) with a set package of benefits for certain health conditions. Frenk formed a small group of people in charge of SP’s design. The Treasury opposed SP on the grounds that the percentage of uncovered population was so large that the costs would be too large. After several meetings, the SP managed to get a signature from the Treasury. However, the Treasury openly opposed the bill in Congress. In November 2002, the Executive sent the bill to the Senate, which also included the creation of the National Commission for Social Protection in Health (CNPSS) to be in charge of implementation.

⁸⁶The commission also introduced modifications to the Isapres Law (18.933) in order to increase the regulations imposed on them.

The Peruvian political parties lacked core ideological values uniting their members. Consequently, they did not behave programmatically in response to the prospect of a health reform (AUS). An outside actor, a USAID funded project, was responsible for the introduction of AUS into the political agenda. The USAID project, *PHRplus*, had worked on AUS since 2004, together with a plan of benefits and guarantees of health services to which those insured would have access. Although different parties introduced bills on the issue, in the case of APRA and UN, the content of these bills was a product of a few advisors and consultants from the USAID project and the private sector. As different interviews recalled, members of PRAES, the continuation of *PHRplus*, not only helped crafting the bills, but also was originally proposed by them.

Whereas parties introduced the issue of healthcare reform into the agenda in Chile, outside actors in the form of think tanks placed the issue into the agenda in Mexico and Peru. The ruling party in Mexico, PAN, displayed a lack of commitment to the healthcare reform during the introduction of the issue into the agenda. In Peru, APRA did not lead the agenda-setting process of the Peruvian reform. In the context of parties that have no core values or whose values do not relate to the issue of healthcare, external actors in the form of Funsalud in Mexico and USAID in Peru were determinant to the introduction of the reforms into the agenda.

Debate

The core values of the Chilean parties were directly related to the prospect of a reform that aimed to expand access to healthcare. This led the parties to commit to the definition of specifications of the policy regarding financing and implementation, which determined the sustainability of the reform in the long term. Whereas the center-left looked to move the health system closer to the goal of equity, the right sought to defend the interests of the private sector. A point of

convergence, however, between left and right was their interest in a feasible process of implementation for AUGE. In Peru and Mexico, there was no political commitment to the reform.

If we think of the Mexican parties through a dichotomous frame (programmatic or not), we would expect PAN to behave programmatically. However, the health reform was not directly related to the core value of the party, Catholicism, and hence the party lacked programmatic commitment to the reform. This defined the process of debate and also the content of the final law that was approved.

In Peru, parties that lacked core values and hence had no programmatic commitments to the reform approved a law that lacked specifications regarding the necessary funding to be implemented. The technocrats behind the design of AUS as well as the congressmen that supported the bill preferred to avoid discussions on infrastructure and funding as these issues were considered controversial and could put at risk the passage of the law.

Technocrats filled the void that the lack of participation of the parties left in Peru and Mexico. Technocrats, instead of party representatives, were the protagonists of the processes of debate. In the case of SP, technocrats from Funsalud, a think tank financed by the private sector, introduced the reform into the agenda. Health Secretary Frenk, former Funsalud leader, led a group of experts that controlled the process of debate around the reform. In Peru, technocrats from USAID funded projects led the process of debate on AUS. Three of these consultants later became health ministers in the country.

Technocrats also participated in the process of reform in Chile. However, they were not isolated from the platforms the Concertación government proposed since most of them had partisan affiliations within the coalition. The role technocrats have during policymaking depends

on the type of parties. If the parties hold a programmatic commitment to the reform, technocrats serve the purpose of developing specific goals. If parties lack programmatic commitment and hence are disengaged from the reform process, technocrats dominate the process and lead to the introduction of poorly specified bills, and equally important, a lack of political commitment to implementation.

Concertación members agreed on a compromise to improve the functioning of the public sector in order to arrive (in the long-term) at a system where public insurance would prevail. The AUGE team thought that it would be hard to just ask for more funds for FONASA and instead decided to go for a short to medium-term approach that involved working with the private sector. If the public system was not able to provide the guaranteed health interventions that people were entitled to, FONASA had the obligation of buying such interventions from private providers. A parallel strengthening of the public sector would take place, as well as imposing restrictions on the discrimination Isapres carried out against their affiliates.

Concertación faced the opposition of the right-wing Alianza and their reluctance to accept the Solidarity Fund (SF), a mechanism of redistribution across affiliates of the public and private sectors, which would take 3% of the 7% compulsory contribution workers made (to either FONASA or Isapres), and then give back to the affiliates adjusting for their risk based on sex and age. Alianza represented the position of the Isapres Association. There was a close relationship between Isapres and the right-wing parties, through which the association provided information to Alianza senators.

The veto Alianza could impose during floor debate in the Senate was a latent threat. Several interviewees noted that Alianza made it clear that they would veto the reform on the floor and therefore the fund had to be removed from the bill. On the grounds that the withdrawal of the

fund from the bill would make it possible to generate broad consensus, Concertación senators in the Health Committee agreed to remove it from the AUGE bill. AUGE, nonetheless, eliminated the vulnerability of private sector members with regard to the 56 diseases the plan included. For the first time since Pinochet's regime created Isapres, the government was able to impose on them the obligation to provide a minimum coverage to their affiliates. The law also established limits to the co-payments affiliates would pay for AUGE diseases (in FONASA and Isapres).

The funding of the health reform was an important part of the discussion. The Financing Law was enacted in August 2003. AUGE was to be funded through a 1% increase of VAT, increased efficiency in the use of health funds, government revenues, and a new universal premium (Blackburn et al. 2005). The Reform Commission, in collaboration with MINSAL's Epidemiology division, calculated the cost of the universal premium that would be taken from the current premiums of affiliates to the public and private sectors. The Treasury is obliged to give resources to AUGE, based on this premium, which has made AUGE sustainable over time. The Treasury showed commitment to fund AUGE from the beginning. Former Superintendent of Health Manuel Inostroza emphasized that AUGE specifications guaranteed resources, diminishing the power of the Treasury. The law established the set of prioritized diseases to be re-evaluated every three years in order to progressively include more diseases that, according to epidemiological studies, were a priority to cover.

A crucial decision the AUGE reformers took was that the implementation of AUGE was to be gradual. The demand for gradualism came from both the left and right, as well as from MINSAL. Concertación and Alianza senators pointed out the need to overcome the gaps between the demand for attention and the actual capacity of the public system. They would start with 25 diseases in 2005, increase to 40 in 2006, and reach 56 by 2007. The government created the

AUGE Technical Secretariat to construct the clinical guidelines establishing what could be done, together with a study of infrastructure gaps to provide a parameter of what could be implemented.

The ruling party in Mexico, PAN, gave its absolute support to the SP bill, but it had no participation in the definition of its specifications. The SP team, a very closed group with very little participation from other members of the Health Secretariat, was pleased with the lack of participation of PAN.⁸⁷ In the words on one of the members, their participation “*would have contaminated [the process]*”. All PAN members voted in favor of the bill in both houses. However, the party did not have enough votes to pass the bill and hence needed the support of legislators from the other two main parties: PRI and PRD.

For several PRD members, SP would lead to the gradual privatization of the health system since the public sector would not be able to cover the demand for services alone. They also considered that having a package of interventions for specific health conditions was discriminatory to those who suffered illnesses outside of this set. PRD never presented an alternative to SP, but a sector of PRD advocated for a national system, an increase of public funding and strengthening the public provision sector so that everyone could access free services. PRD was divided at the time of the vote in the Senate in April 2003. The PRD sector in favor of SP supported the important increase in resources that would reach the states thanks to the reform. The governors were convinced that SP would bring more resources to their states.

PRI votes were extremely important to approve SP (they held 60 out of 128 seats in the Senate). Members of the Frenk team noted how much work they put into lobbying PRI representatives. PRI did not shape the law as a party, but individual PRI legislators introduced

⁸⁷A team of less than 10 people called *La Escuelita* met every Monday for very technical meetings. It was then the job of the Head of the Social Bonding Office Gabriel García to “translate” these discussions for state politicians and legislators.

some additions related to their particular interests. An important addition from Senator Navarro Quintero was an article stating that 3% of the resources destined for SP had to go to the development of infrastructure. SP had partial support of PRI. A key factor that won PRI's support was the large increase in resources for state governments that SP entailed, which have always been important for patronage.

A point of PRI opposition was tied to the Treasury, as they felt that there were not enough resources for SP. Even though then Treasury Secretary Francisco Gil (PRI) remained removed from the process, Sub-Secretary Carlos Hurtado did "*the front line battle*", as he called it. Hurtado noted that one of President Fox's advisors called him to say that this was enough opposition and Secretary Gil instructed him to stop the resistance in the Senate. The arrangement was that the bill had to include a transitory article stating that families would be affiliated to SP in a gradual manner.

The funding of SP was a concern of the Treasury. However, neither of the parties propelled a discussion regarding the specific sources of funding for the reform. The Frenk team and PAN members argued that the gradual implementation of the reform would prevent running into an insufficiency of resources. As a member of the Frenk team noted, the high prices of oil at the time were favorable to go on with a reform without making any fiscal changes.

The SP team had decided that the unit of insurance was going to be the family, in order to mirror the social security system schemes. Also mirroring IMSS and ISSSTE, SP would have 3 main sources of funding: 1) Social Contribution (CS) per family, paid by the federal government, 2) State Solidarity Contribution (ASE) paid by the state governments, and 3) Federal Solidarity Contribution (ASF). However, several governors showed reticence to provide the State Solidarity Contribution (ASE) once the law was approved.

The Health Secretariat had the obligation of putting together an Infrastructure Master Plan for the reform. As Frenk noted, this plan would help to change a system where decisions regarding new infrastructure were politicized. This was, nevertheless, not a key point of debate during the legislative process of the SP bill.

In Peru, the Health Committee (HC) in Congress discussed AUS for the first time in September 2008. At the HC, two main advisors were in charge of an AUS working group; one of them was Aníbal Velásquez, from the USAID funded project PRAES. Then president of the HC, Wilson (APRA), noted that the point of these meetings was to generate consensus between the different actors involved. However, those who represented the opposition to AUS disagreed and argued that the meetings were mainly to convince them.

The right-wing coalition UN introduced one of the first bills (and the final law that Congress passed was very similar to this bill). However, their representatives in Congress rarely participated in the debates within the HC and on the floor. UN advisors and private sector representatives, Jorge Ruiz and Alberto Valenzuela, had to gather the support of the UN legislators.

AUS would provide coverage to the 50% of the population that was uninsured, through the expansion of the healthcare scheme for the poor (*Seguro Integral de Salud*, SIS). SIS would expand in order to cover informal workers regardless of their income. Further, through PEAS (a package of benefits and guarantees of health services), the coverage of health conditions of those affiliated to SIS would gradually equate that provided by the social security system. PEAS would be revised every two years.

During the HC meetings and on the floor, the funding of AUS failed to become the center of discussion. AUS was going to require a good amount of funding for two main areas:

strengthening the supply side (mainly infrastructure and human resources) and financing the demand (the state would cover the services for poor people completely and partially for those with some acquisitive power). Surprisingly, not much debate went into how to fund this ambitious proposal. In the Executive, the issue of funding did gather more attention. MEF was concerned about the lack of financing plan behind AUS. However, MEF and MINSA agreed that AUS would pass but without any certainty regarding future funds.

If the AUS bill did not specify the amount of monetary resources needed, neither did it specify the sources. The bill only mentioned that the funds would come from general taxes and APRA legislators emphasized that the Executive would be in charge of determining the details once AUS was approved. Moreover, several AUS promoters emphasized that engaging in a discussion about funding and its sources was going to put the passage of the law at risk. The former health ministers as well as the UN and APRA legislators noted that the context of consensus that was achieved had to be used to launch AUS, even though that meant not having secure funding. In the words of former Health Vice-minister Melitón Arce (APRA), “*AUS had a lot of pragmatism.*”⁸⁸

AUS passed a vote in Congress in March 2009. Surprisingly, one of the left-wing parties that had opposed the reform since the beginning, UPP, on the grounds that it promoted a fragmented system and the expansion of the private sector, voted in favor of the law. The health minister at the time noted that they “*convinced UPP.*” The advisor to UPP leader Francisco Escudero explained that Congressman Wilson and the health minister convinced Escudero of the positive sides of AUS. Wilson’s advisor’s account varied from this. He noted that they agreed with Escudero on UPP voting in favor of AUS and then APRA would vote in favor of a law

⁸⁸During a presentation at a HC session, the president of the National Association of MINSA Doctors emphasized that “*there cannot be any significant and substantive change without policies made to resolve the situation of human resources.*” He also stated that health policies in Peru should not be “*mere demagogic actions that lead nowhere.*”

Escudero had been trying to pass for a while. Right after AUS passed, the discussion of Escudero's bill was included in the HC agenda "with priority" and finally approved with the votes of all APRA legislators.

The private sector devised different strategies across the three cases under study in this dissertation. The role of the private insurance sector was highly relevant during the legislative process of the Chilean reform through the influence of the right-wing parties UDI and RN. In Peru, through their representatives strategically placed in Congress and the Executive, the private providers and private insurance companies had an active participation in the policymaking of the reform. In contrast, in Mexico the role of the private sector was not very salient. Although they financed Funsalud, the think tank that hosted one of the key actors of the reform, their representatives did not participate until the implementation of the reform had started.

The process of debate of AUGÉ shows that parties with programmatic commitments to a policy worry about how they can deliver on their promises. The commitment of the major political actors developed during the process of debate proved to be important for the definition of crucial specifications of the reform regarding funding and implementation.

During the SP debate, Mexico had strong parties: well funded, disciplined, with offices across the country, and the ability to capture a large percentage of the vote. PAN had a core value uniting its leaders (Catholicism), but SP was not directly related to this value, and therefore the party remained distant from the debate process. PRI did not have core ideological values, whereas only some PRD members advocated for a system where the state was the main provider of health services, but they could not influence the vote within the party and the final decision. Consequentially, parties did not shape the specifications of the Mexican reform and a commitment to SP and its implementation was never forged among the main political parties.

The process of debate of AUS lacked the participation of the main political parties. The Peruvian parties lacked core values and therefore they lacked programmatic commitments to the reform and did not shape the specifications of the policy. Instead, technocrats were the protagonists of the process of debate of AUS, which defined not only the process but also the contents of the law passed. Congress passed a law that lacked the necessary funding to be implemented. The parties in Congress were not part of an exhaustive process of debate about the reform. Instead, its members tried to avoid the discussion of many important issues such as funding, the feasibility of the project given the shortage of human resources and infrastructure, as well as its sustainability.

Implementation

The long-term goal of the healthcare reforms in Chile, Mexico and Peru was largely similar: achieving an expansion of access to healthcare services, both in terms of the population as well as treatment of different diseases. When we look at the results of the implementation of the reforms, we see commonalities. There was an increase of people covered, as shown in table 1, in the three countries.

Table 6.1. Formal Coverage: Percent (%) of Population with Insurance

	Chile	Mexico	Peru
Before Reform	91	46	49
2016	98	93	73

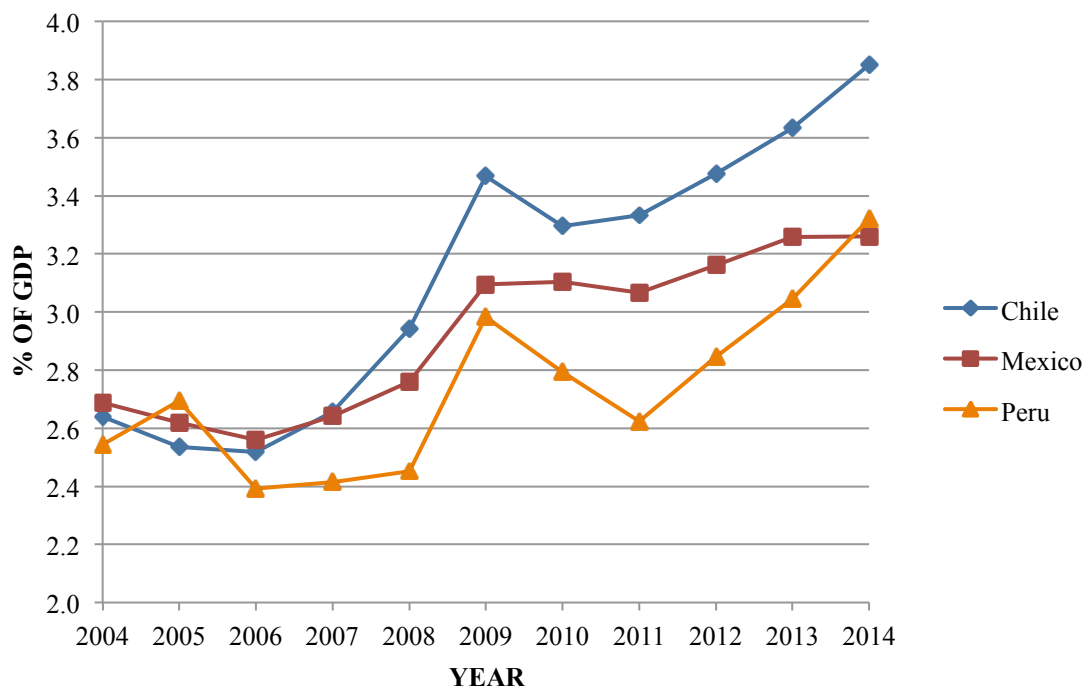
Note: Before Reform years 2003 for Chile and Mexico and 2007 for Peru

It is important to point out that although Chile had over 90% formal coverage before the reform, as Pribble (2013) has documented extensively, there were still important barriers to effective access. In the cases of Mexico and Peru, although we see a considerable increase in formal coverage, we must be cautious in considering this an indicator of success as the

constraints to effective access of people covered “on paper” have gotten in the way.

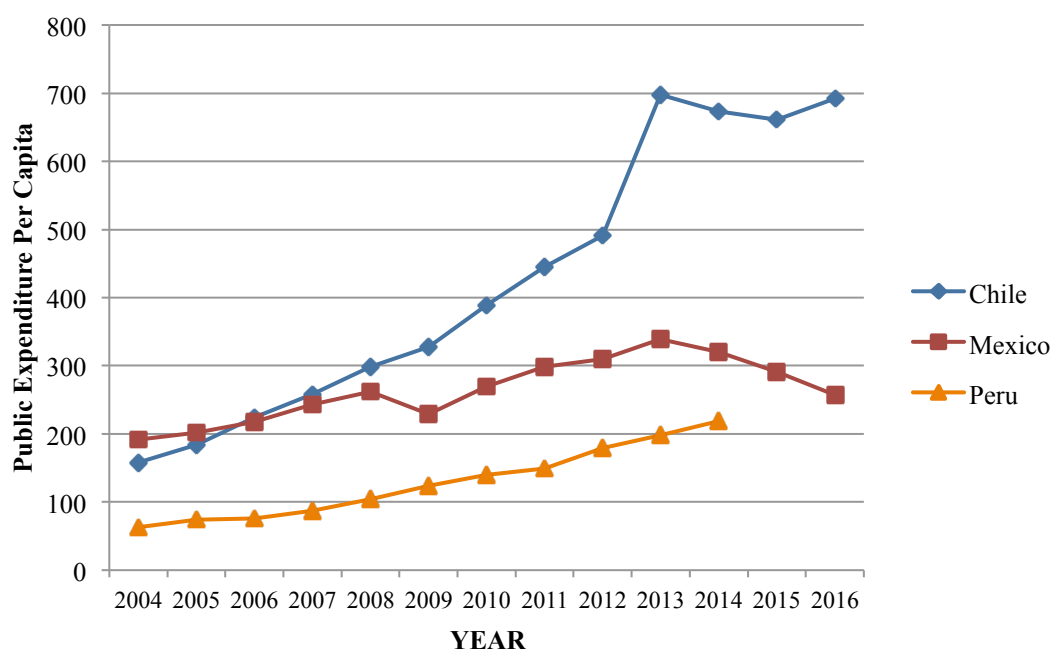
Another commonality we can observe is a general increase in state funding for health. However there are important differences. Figures 2 and 3 show that whereas the increase in funding for the health sector has been stable in Chile, the funding of the reforms in Mexico and Peru has not been constant. The public health expenditure, measured as a percentage of GDP and in current USD spent per capita, has grown in a more constant fashion in Chile, in comparison to Mexico and Peru. Moreover, whereas the budget for the reform in Chile has grown constantly, the budget in Mexico saw a reduction of almost 3% for 2017, and the SIS budget saw a reduction of almost 3% for 2016 and of 15% for 2017.

Figure 6.2. Funding for Health Reform: Public Health Expenditure (% of GDP)



Note: 2004 marks the beginning of implementation in Chile and Mexico and 2009 in Peru.

Figure 6.3. Funding for Health Reform: Public Health Expenditure Per Capita (USD)



Another key difference is that the growth in formal coverage of Chileans has been accompanied by a parallel development of the required resources (infrastructure and human resources) to provide services. This has not been the case in Mexico and Peru, leading to a deficiency in terms of effective access to healthcare for the population. The lack of commitment from the main political actors in the process of reform in Mexico and Peru led to a poorly specified legislation and a deficient implementation.

Following the schedule established in the law, in July 2005, AUGE began with 25 of the 56 planned diseases. The first AUGE decree, enacted in 2004, established the package of diseases and guarantees. The decree was to be updated every three years, keeping the same number of diseases or increasing them, based on their importance relative to the disease burden of the country, availability and cost of interventions, and availability of resources (Lenz 2007). AUGE also established the creation of an Advisory Board, formed by experts from outside the

government (from health and economy). Before updating the AUGE decree, the board revises a first proposal and advises MINSAL on its applicability.

The Treasury gave additional funding to MINSAL for the implementation of AUGE to enhance the resources of the public sector. An important part of it was also to buy more equipment and hire more personnel in order to implement AUGE. Additionally, the AUGE Technical Secretariat had to work with health services across the country in order to make sure that attention for non-AUGE diseases would continue to work. Another important institution the reform introduced was the Health Superintendency. It is responsible for enforcing the fulfillment of guarantees by both FONASA and Isapres, and supervises the performance of both insurers and providers.

In March 2006, Concertación's leader Michelle Bachelet (PS) became president of Chile. She committed to AUGE's continuation during the 2005 presidential campaign. According to schedule, in July 2006, the implementation of guarantees for 15 new diseases followed, and then for the last 16 (total 56) in July 2007. When they attempted to increase them to 69, the Advisory Board opposed this because there were not sufficient conditions to provide guarantees for more than 56 diseases. There was heavy investment in equipment and hiring new health personnel to expand the public resources, which helped to contain the growth of waiting lists and the purchase of services from the private sector.

Sebastián Piñera (RN) became president of Chile in March 2010. Since the campaign, the right-wing leader made it clear that AUGE would continue during his government. He even ran on the offer of "AUGE 80" during the 2009 campaign. Indeed, there was an addition of guarantees for 13 extra diseases in July 2010 (a total of 69) and finally 11 more in July 2013, making a total of 80 diseases.

During Bachelet's second term in office (2014-2018), the investment of funds into the health sector has been the highest in the history of the country. An important part of this budget has been directed to the development of infrastructure (hospitals and primary care centers) and new equipment. As Chief of MINSAL's Institutional Planning Division Pietro Cifuentes noted that the high compliance rate that FONASA has for AUGE could be explained because the resources it gets every year are tied to its performance, which is an incentive to resolve issues promptly. AUGE has strengthened the primary care level, which is important to treat diseases in time as well as to transition from a system based on curative medicine to a preventive one. Moreover, this level of care is critical for low-income groups (Pribble 2013).

For the implementation of SP to begin in Mexico, given the autonomy of the states, each one of the 31 state governors and the head of the Federal District had to sign "coordination agreements". By December 2003, 7 months after the approval of the law, no single governor had signed the agreement. The main reasons: 1) their reticence to provide the State Solidarity Contribution (ASE) and 2) the reduction of their ability to control the distribution of resources. The SP team managed to convince the state governors by emphasizing the transfer of fresh monetary resources and negotiating *how* the state governments could provide their ASE. Other things, such as soccer fields and fountains could count towards the ASE, and that they would only start contributing in cash in 2010. Members of the team and Frenk himself affirmed that this was the only way to gain the allegiance of the governors, and that they did not foresee the reticence of state governors to contribute to SP during the legislative process.

These arrangements between federal and state governments regarding what would count as contribution and the independency of the local SP offices hurt the sustainability of the reform. One of the major hurdles the implementation of SP has faced is the lack of accountability of state

governments. According to official SP data, most states only report 50% of the use of these resources; and some of them do not even report at all.

The number of families affiliated to SP saw rapid growth during Felipe Calderón's term (2006-2012), growing to over 43.5 million people by December 2010 (37% of the population). The budget assigned for the reform also grew. However, the Treasury introduced a reform to the SP bill in 2010 that changed the Social Contribution provided by the federal government, which implied that all states, without exception, losing a significant amount of resources (Laurell 2013). According to official accounts, this was a necessary change since the states were affiliating the same individuals as part of different families. This has been highly contested as many argue that the Treasury introduced this modification due to a lack of funds. This change, added to the fact that many states still do not contribute the whole amount of the ASE, has been one of the major problems faced by SP.

With the increase in affiliation, the demand for services has definitely gone up, but the development of infrastructure, as well as the increase in human resources, did not advance at the same rate. This imbalance has affected the level of effective access for SP affiliates, particularly in rural areas where people might be affiliated but no public clinic is close to them so they have to be referred to a different location. There are striking differences in terms of infrastructure and effective access across states in Mexico.

By providing financial protection to those from the uncovered population, SP could gradually close the gap between those who were part of the social security system and those outside it. Indeed, the differences in public spending per capita for social security members versus the SP population have reduced.⁸⁹ However, the gap to be made up in infrastructure and

⁸⁹According to Flamand & Moreno (2014), the government spent 2.15 times more per capita for social security members than for those uninsured in 2000 (before SP) and 1.5 more in 2009 (after SP).

resulting limitations in effective access to healthcare experienced by SP affiliates has not allowed for these two different segments of the population to come closer.

AUS passed a vote in the Peruvian Congress in March 2009. A special commission within MINSA, aided by the USAID funded project PRAES crafted AUS's National Implementation Plan in January 2009. The set of benefits and guarantees of health services that all health insurance institutions would be bound to fulfill (PEAS) considered 140 illnesses, for which timely and quality service had to be guaranteed. When asked about how ambitious the package was, given the shortage of infrastructure and human resources in the public system, the PRAES member in charge of PEAS's design argued that infrastructure could be strengthened later. Indeed, MINSA began to implement AUS in some areas of Peru without the necessary infrastructure and human resources.

When the implementation of AUS started, 40% of the population (over 11 million people) was affiliated to SIS, the state's healthcare scheme for the poor.⁹⁰ With the introduction of AUS, more people affiliated to SIS, but before 2013 SIS's funding did not see significant changes. Lack of infrastructure and shortage of human resources got in the way, problems that could not be solved without a necessary injection of funding. The process of debate of AUS produced a law that lacked the necessary funding for implementation. During debate, plans to strengthen the infrastructure of hospitals and health centers, overcome the shortage of doctors, nurses and other health personnel never emerged.

President Ollanta Humala (2011-2016) was the leader of the only party (PNP) that voted against AUS. However, in July 2012, Midori de Habich, former leader of the USAID funded projects, who had been actively involved in the agenda-setting and debate of AUS became health

⁹⁰The poverty rate in Peru at the time was just over 30% and not every poor citizen was affiliated to SIS. However, people who were not poor were in the system). Also, some were affiliated to SIS's semi-contributory scheme.

minister. MINSA started the implementation of AUS across the whole country. An important injection of funding for the health sector arrived: whereas SIS's budget from 2008 to 2012 was between 400 and 500 million soles, it was 900 million (around 300 million USD) by 2013.

The revision of PEAS every two years never happened. Most public health facilities were not able to provide PEAS due to their lack of infrastructure and human resources. In that context, revising the plan did not make much sense. The conditions PEAS included were unrealistic, for instance, in terms of the time that the personnel should take to provide a certain service or the exact number of tests that they should apply to a patient.

By 2017, over 55% of the population was affiliated to SIS. While the number of affiliates grows, so do the complaints regarding the capacity of the public system to respond to this enormous demand. In theory, SIS could cover everything today, as they can also access a Complementary Plan to cover any other health intervention up to 2,600 USD and Extraordinary Coverage in case the cost for these extra interventions surpasses this sum. Moreover, 40% of SIS affiliates are in rural areas of Peru, precisely where access is more limited. When the required technology or personnel is not available in a facility, patients can be referred to the nearest facility able to cover the need. In the great majority of cases, these patients do not go to the referred facility since they cannot afford transport to a different facility.

AUS brought the possibility of increasing SIS's funding, which more than doubled between 2012 and 2014. The main concern of MINSA officials is the stability of the funding that they have received in the past three years. MEF reduced SIS's budget for 2016 by almost 3% and by 15% for 2017. There is uncertainty with regards to how much money MEF will give year by year. Many experts concur that the best way to give stability to the funding assigned to AUS is to

calculate a premium that could become the base for the assignment of funding, then funding would increase as the number of affiliates increases.

Alternative Explanations

I have shown the importance of whether the core values of political parties relate to the issue of reform (programmatic commitments). This defines qualities of the policy and its implementation. If the parties lack core values around which their leaders cohere or if such values do not relate to the policy issue, the quality of the legislation regarding funding and infrastructure will suffer.

The presence of strong left-wing parties in government cannot alone explain the introduction of reforms into the agenda or the passage of reforms. Under right-wing parties, we can also see these reforms being introduced and approved. The analysis provided shows the importance of paying more attention to these cases. The ideology of the party or coalition in government does make a difference in terms of the direction they will push the reform towards. However, only if the core values of left- and right-wing parties relate to the policy issue at stake, will they have a programmatic commitment to the policy and care to shape crucial specifications of the reform that will guarantee its implementation. Where the parties lack core values, like the case of Peru, this programmatic commitment will be absent.

Economic growth does not explain the differences across the reforms. If we look at GDP per capita adjusted by Purchasing Power Parity, we can see similar growth in the three cases, with a constant increase since the early 2000s (and a slight decrease around 2008). This variable did not define the specifications regarding funding and infrastructure. The GDP per capita of Chile and Mexico around the time when their reforms were being discussed (2002-2004) was very similar (~11,000\$), but we observe significant differences across their policy reform. The GDP per capita of Mexico is definitely higher than Peru's and yet they produced very similar reforms.

Garay (2016) shows that the presence of electoral competition was important for the expansion of social policy in Chile and Mexico, including healthcare reforms. In the case of Peru, the author explains, given the absence of consecutive reelection, electoral competition could not foster the expansion of social policy. However, the healthcare reform enacted in Peru in 2009 had similar effects to the Mexican reform in terms of formal coverage. How do we explain the development of reform in Peru? The answer pertains not only to the Peruvian case but also to Mexico: the role of technocrats becomes highly important in the context of parties that have no commitment to reforms seeking to expand access to healthcare. Moreover, the strong participation of these outside technocrats, given the lack of commitment of the main parties, also explains the low quality of legislation in terms of funding and infrastructure assessments.

Regarding the presence of diffusion across cases, although there was awareness of the need for expansion of access to healthcare as well as knowledge of the reforms taking place in other countries such as Colombia, the policymakers involved in the three cases of reform did not attempt to copy content. Whereas we may allow that the recognition of a need for reform was related to a diffusion effect, there was no adoption of the content of other models. The role that USAID in Peru and Funsalud in Mexico had in setting the issue into the agenda is a form of diffusion, which comes through an international network of technocrats. These technocrats were pushing for some form of expansion of healthcare. However, they did not copy the content of the bills from country to country. Political parties gave these networks the space to direct the processes of reform, given the parties' lack of commitment to the reforms. Moreover, the Chilean and Mexican reforms took place around the same time. There was not enough time between the implementation of the reform in Chile (2005) and Mexico (2004) and the beginning

of the policymaking process in Peru (2006) for the Peruvian policymakers to observe the failure or success of the reforms in Chile and Mexico.⁹¹

An alternative argument also worth exploring is the role of the president. The presidents were supportive of the bills in the three cases analyzed in this paper. The difference is in terms of the commitment the presidents showed to the discussion of the bills' specifications. Whereas in Chile, the president and leader of the center-left coalition shared with his party a commitment to the feasibility of the reform; in Mexico and Peru, the presidents were as uninvolved in the definition of specifications as their parties.

Conclusion

The Chilean case shows one path to social policy reform, the *partisan path*. The center-left wing parties from Concertación introduced the health reform into the agenda. In alignment with its core values of equality and social inclusion, the coalition shaped AUGE's specifications. At the core of the right-wing UDI and RN's values was a market driven economy as well as a strong private sector. These parties shaped AUGE according to their values as well as pushed for a specific plan of implementation and long-term funding. Instead, in Mexico and Peru, we observed a *non-partisan path* of reform, in which technocrats dominated the policymaking process.

In Mexico, at the core of the right-wing PAN's ideology was Catholicism. The reform was tangential to this core value. Consequently, PAN did not shape the specifications of the reform. An important sector of PRI and PRD supported SP due to a large increase in resources for state governments that SP entailed. The lack of programmatic commitments from the Mexican parties

⁹¹A step necessary for diffusion to take place (Weyland 2006).

hampered the implementation of SP. It fell short at its implementation due to a lack of funding, shortage of infrastructure and low levels of accountability at the state level.

In Peru, parties without core values, which did not have any commitments to the health reform, had very little discussion in terms of the necessary specifications (regarding infrastructure and funding) for the reform. The implementation of the Peruvian reform has been contingent on short-term factors such as the presence of individual actors, and there is no stability in terms of funding.

The Mexican and Peruvian cases show that when parties lack commitment to the policy reform, individual technocrats dominate the process. The lack of commitment from the main political parties in the reform processes had as its main repercussion poorly specified legislations and deficient implementations. A policy designed by technocrats still needs to be carried by committed politicians during its implementation to succeed. The reforms sought to tackle a system that discriminated based on the socioeconomic status of their citizens. Whereas more Mexicans and Peruvians enjoy formal coverage thanks to the reforms, the shortage of means to effectively provide such coverage hinders the success of the reforms.

CHAPTER 7: CONCLUSION

In the last decades, there have been several attempts to tackle the disparities of the healthcare systems in Latin America, where access to healthcare has been shaped by the socioeconomic status of the citizens. The quality of these reforms seeking to expand access to healthcare has varied. Whereas one could focus solely on the success of a reform's implementation, in this study I sought to shed light on how the political process behind the formation of these reforms can severely affect the prospects for increasing equality in the system.

The variation in the quality of reforms seeking to expand access to social benefits prompted multiple studies to focus on how the strength and organization of left-wing parties in the cases under study helped to explain these differences (Huber & Stephens 2010, Murillo 2005, Pribble & Huber 2013, Pribble 2013). However, attempts to expand access to healthcare have also been presided by right-wing parties. A small, but important, number of studies in the last couple of years have given attention to the healthcare reforms enacted when right-wing parties were in power.⁹² Electoral competition and social mobilization are found to explain the expansion of social policy in the region, regardless of party ideology (Ewig 2016, Fairfield & Garay 2017, Garay 2016). These theoretical frameworks help us understand how in Mexico, given the lack of social mobilization, the competition from the left-wing PRD pushed the right-wing PAN to undertake a healthcare reform seeking to expand access. Nevertheless, the process behind how

⁹²In a similar vein, Niedzwiecki & Pribble (2017) study reforms enacted by the right in Chile and Argentina, showing that they have either maintained the status quo of healthcare policy already in place or allowed policy drift.

Seguro Popular reached the political agenda and the role of PAN in the development of the reform deserve further attention. Following this framework, given the lack of electoral competition as well as social mobilization in Peru, we should not expect the development of healthcare reform in this case. The Peruvian AUS, however, shared the same results as the Mexican reform in terms of formal coverage.

The present study has developed a framework that helps us understand how reforms seeking to expand access to healthcare may emerge in the context of right-wing parties in power, what actors are behind their development and how those actors have an impact on the quality of legislation and its implementation. In a context of international awareness regarding the need for policy to expand access to healthcare, and in a domestic context characterized by parties in power that were not engaged in the issue of healthcare reform, individual technocrats from organizations such as USAID in Peru and Funsalud in Mexico led the agenda-setting process of the reforms. In a context of a lack of political commitment from the main parties, these technocrats without partisan ties led to poorly specified legislation during debate, which fell short at the implementation stage since its funding became unstable and the development of infrastructure did not meet the needs.

Chapter 2 presented a theory of how the programmatic commitment (and lack thereof) of political parties to the reform in question affects the legislation enacted and its implementation. Although previous research finds that the presence of programmatic parties is an important predictor of successful policy reform (Scartascini et al. 2009, Stein & Tommasi 2007), these studies overlook the process behind *how* programmatic parties affect policymaking. Programmatic parties have core values uniting their leaders and driving the party program. Whereas certain policy issues are directly related to the core values of a party, others are not.

This theory posed that the participation and impact of parties depends on whether a specific policy relates to their core values and hence generates a programmatic commitment to the policy in question. Moreover, Chapter 2 described the logic of the case selection used in order to test this theory and the process tracing conducted to collect evidence.

The importance of programmatic parties for democracy and representation has been deeply studied (Aldrich 1995, Levitsky & Cameron 2003, Mainwaring 2018, Mainwaring & Scully 1995). However, analysis of how this party feature has an impact on policymaking has been neglected. Chapter 3 showed that, in Chile, the programmatic commitment of the left-wing coalition Concertación, which was present because the issue of healthcare reform related to their core values of equality and social inclusion, led the coalition to introduce the issue into the agenda. The right-wing opposition coalition, Alianza, had core values of a market driven economy and a strong private sector, which also related to the reform. Therefore, during debate, both coalitions shaped AUGE's specifications according to their values, while pushing for a gradual plan of implementation and long-term funding. Moreover, the analysis of the Chilean case revealed that the engagement of the main parties in crafting the specifications of AUGE forged a commitment of the parties to the future implementation of the reform. This political commitment, present both for party leaders in Congress and the central government as well as for those at the local level, supported the development of infrastructure and increase of human resources for the reform throughout the country.

To further support the argument of the importance of the connection between a reform and the core values of political parties, Chapter 4 examined the case of Seguro Popular in Mexico. The programmatic party in power, PAN, which had Catholicism as the core value uniting its leaders (Hawkins et al. 2010, Magaloni & Moreno 2003), was disengaged from the policymaking

process. This chapter showed that PAN did not place the issue of healthcare reform into the agenda. It was a small group of technocrats led by Health Secretary Julio Frenk that presented the proposal of reform to PAN. Although a few of these technocrats were close to PRI, none were tied to PAN. Frenk had worked on this proposal for almost a decade before becoming health secretary, with Funsalud, a think tank financed by the health business sector. The absence of connection between the core value of the party and the reform led to a lack of programmatic commitment to it. PAN, as well as a PRI that lacked core values and a PRD where only a sector held a programmatic commitment, did not participate in the definition of policy specifications. Instead, individual technocrats dominated the debate, and in the context of disengaged politicians, lead to a legislation that lacked stable funding and a clear infrastructure plan.

During implementation, the Mexican Seguro Popular fell short due to unsteady funds, insufficient infrastructure, and low levels of accountability at the state level. Leaders from the three main parties in Mexico at the national and local levels supported the reform due to the large increase in resources for state governments that it entailed. However, when the implementation of the reform started, several state governments refused to contribute funds for it (which the law required). Moreover, most of them do not report how they use the funds that the federal government transfers for the reform. In contrast to Chile, there has been subnational political resistance to the implementation of the healthcare reform. The lack of programmatic commitments from the Mexican parties hampered the implementation of Seguro Popular. These parties did not pursue a reform that could be implemented effectively and could be sustainable over time.

Chapter 5 sought to answer the questions of how a reform is adopted and the consequences of this process in the context of non-programmatic parties. In the absence of policy programs

across all major political parties in Peru (Cameron 2011, Kitschelt et al. 2010, Levitsky 2013, Levitsky 2018, Levitsky & Cameron 2003, Tanaka 2005), the emergence of a healthcare reform seeking to expand access to healthcare is incredibly puzzling. The Peruvian parties lacked core values uniting their leaders and therefore lacked connection to the issue of healthcare reform. They did not lead the agenda-setting process, but instead, technocrats without partisan ties not only introduced the AUS reform into the agenda but also led the process of debate. The Peruvian parties did not participate in crafting policy specifications. Technocrats from USAID and private sector representatives dominated the process and crafted a poorly specified policy as they considered that provisions regarding funding and infrastructure were unnecessary during the debate stage but rather a risk for the passage of the bill. The private sector representatives, who wanted to make sure that the reform would protect their interests were very active during the policymaking process and collaborated with the USAID technocrats to produce a bill poorly specified for effective implementation. The Peruvian parties lacked programmatic commitment to the AUS reform and allowed the passage of low quality policy.

The development of the Peruvian reform was slow during the first years of implementation, given the lack of funding and the infrastructure gap in the public sector. Although the fact that one of the USAID technocrats who had been involved since agenda-setting became health minister led to an increase in funding, funds have not been stable. Moreover, a shortage of infrastructure and human resources constrains the provision of healthcare to those covered by the reform. The promoters of AUS did not provide a plan to give a feasible and sustainable solution to the problems Peru faced regarding access to healthcare.

A comparative analysis of the three cases under study, the processes of healthcare reform in Chile, Mexico and Peru, developed in Chapter 6, showed how the programmatic commitments of

parties affect the quality of healthcare reforms. Reforms can follow a *partisan path*, like in the Chilean case, in which parties with core values closely tied to the policy in question define a reform's specifications and commit to its implementation. Reforms can also follow a *non-partisan path*, as was the case in Mexico and Peru, in which parties are not committed to the reform and hence do not engage in crafting key specifications for its implementation. Both paths can lead to reforms that increase formal coverage and even funding of the health sector. The key difference, however, is in the feasibility of ensuring access to healthcare and the sustainability of funding. Although the ruling parties in Mexico and Peru supported the reforms, under the command of their party leaders, President Fox and President García, respectively, they were completely disengaged from the discussion of specifications regarding the necessary resources for implementation.

The lack of participation of the main political parties also implies a lack of commitment to the reform during implementation, which hinders the success of the reform. A policy designed by technocrats still needs to be carried by committed politicians during its implementation to succeed. Although more people may enjoy formal coverage thanks to the healthcare reforms in Mexico and Peru, the shortage of means to effectively provide access to healthcare becomes a major obstacle. Chapter 6 showed the costs of a lack of programmatic commitment to a reform.

Political parties with core values that unite their leaders and drive their party programs are not only important to guarantee political representation and democracy, but also for policymaking. However, not all programmatic parties engage equally in the policymaking process of healthcare reforms. If the core values of a party are not related to the policy issue at stake, the parties lack interest to participate in the process and commitment to craft a feasible and sustainable reform. The same negative impact on the quality of reform is present when parties

without core values are disengaged from the policymaking process. In a void of political commitment, technocrats without partisan links dominate the process and generate poorly specified legislation that falls short during implementation due to a lack of funding and infrastructure.

Generalizability and Issues for Further Research

How generalizable is the theoretical framework developed in this study? The problems of fragmentation of the healthcare system and lack of access to healthcare services that the reforms studied in this dissertation sought to tackle are present in many other countries in Latin America. In that sense, this theory should be transportable to explain the big variation in the quality of policies in other Latin American cases, with similar problems of fragmentation and incomplete access to healthcare. Focusing on this region, as well as others, several studies have demonstrated the importance of programmatic political parties for interest aggregation and a functioning democracy in general. In this study, I have shown that programmatic parties are also important for policymaking, but that we must pay attention to the conditions under which they develop a programmatic commitment that affects the quality of legislation and ultimately the actual implemented policy.

The generalizability of the findings of this study can be put to test by analyzing whether the connection (or lack thereof) between a policy issue and the core values of parties generated similar results in other cases of social policy reform. An analysis of the implications for policymaking that programmatic versus non-programmatic parties have is particularly relevant in current Latin American politics. The region has experienced the disappearance of several programmatic political parties and the development of multiple non-programmatic parties (Kitschelt et al. 2010, Levitsky 2001, Levitsky et al. 2016, Mainwaring 2018, Mainwaring and

Zoco 2007). As the political parties literature shows, there is a widespread struggle among Latin American countries in terms of party building and institutionalization. Most parties have become unstable, unable to gather support throughout the national territories, and void of programmatic values that can help voters to distinguish among them. In a context where only few of the many Latin American parties have core values uniting their leaders, and even fewer have core values that relate to the expansion of social benefits, understanding the consequences of this phenomena for policymaking becomes even more crucial.

Further research could go in different directions. Within the issue of healthcare, one potential area for future studies relates to the variation in the development of the private healthcare sector and its impact on the development of reform. Although in all Latin American countries there is coexistence between the public and private sectors in the provision of services as well as insurance, there is a lot of variation. It is important to understand how the different status and prominence that the private provision and insurance sectors enjoy has shaped the prospects of healthcare reform and ultimately the quality and accessibility of healthcare across time and countries. Another avenue for further research involves a focus on political attention to health among the public and how this reflects the relevance of the issue for political parties seeking support from citizens. If political parties are uninterested in healthcare policy, we must evaluate whether this is in response to a lack of interest from citizens, as they devise the best strategy to gather votes.⁹³

In order to assess the transportability of the findings of this study to other social policy issues, further research should focus on how the presence or absence of programmatic commitment from political parties affects the process of education, income-support, or pensions

⁹³The work of Green-Pedersen and Wilkerson (2006), comparing the United States and Denmark, goes in this direction.

reform. Moreover, the application of the theoretical framework developed in this dissertation could be assessed in other policy realms, such as economic reforms, in order to assess the extent to which the programmatic commitments of parties and the role of technocrats can shape the quality of legislation in other policy areas.

APPENDIX A: LIST OF INTERVIEWS

The following list provides the names, position (at the moment of the interview), place, and date of interview of all the interviewees that were part of this study, who also agreed to disclose their names and positions. The interviewees who preferred not to disclose their names are not included in this list.

Accorsi, Enrique. Former PPD Deputy, member of the Medical Block; former President of the Medical College. Santiago de Chile, Chile, April 27, 2016.

Acosta, Julio. SIS Chief. Lima, Peru, December 2, 2015.

Acosta, Rossana. Director at Libertad y Desarrollo (LyD). Santiago de Chile, Chile, May 12, 2016.

Aguilera, Nelly. Former Head of the Economic Analysis Unit at the Health Secretariat. Mexico City, Mexico, July 23, 2014.

Aguilera, Ximena. Former Head of the Public Health Division at MINSAL. Santiago de Chile, Chile, May 5, 2016.

Albornoz, Ana. CEO of Clínicas de Chile. Santiago de Chile, Chile, May 10, 2016.

Alfonso, Alejandro. CEO of ABC Medical Center; representative of the National Association of Private Hospitals. Mexico City, Mexico, August 11, 2016.

Arce, Melitón. Former Health Vice-Minister; former Superintendent of SUNASA. Lima, Peru, February 6, 2016.

Arcil, Ghislaine. Former Head of the Network Planning Division at MINSAL. Santiago de Chile, Chile, May 12, 2016.

Arellano, José. Senior Researcher at Corporación de Estudios para Latinoamérica (Cieplan); PDC member; former Director at the Treasury. Santiago de Chile, Chile, May 4, 2016.

Armenta, Dolores. Director of Medical Expenses and Health at the Mexican Association of Insurance Institutions (AMIS). Mexico City, Mexico, August 8, 2016.

Arreola, Héctor. Health Observatory Coordinator at Funsalud. Mexico City, Mexico, July 15, 2016.

Arroyo, Juan. Former ForoSalud National Coordinator. Lima, Peru, February 10, 2016.

Artaza, Osvaldo. Former Health Minister of Chile. Mexico City, Mexico, July 25, 2014.

Ayestas, Carlos. Executive Director of Health Insurance at MINSA. Lima, Peru, June 5, 2017.

Barraza, Mariana. Researcher at the Economic Analysis Unit of the Health Secretariat. Mexico City, Mexico, August 15, 2016.

Barría, Soledad. Former Health Minister of Chile; PS member; former advisor of the Health Minister; former advisor of the Medial Block. Santiago de Chile, Chile, April 21, 2016.

Barredo, Alfredo. Former Manager of the Benefits Division at EsSalud; former Operations Manager at SIS. Lima, Peru, February 24, 2016.

Bastías, Gabriel. Professor at Pontificia Universidad Católica de Chile. Santiago de Chile, Chile, April 4, 2016.

Benavides, Claudia. Former Health Expert at the Public Budget Division at MEF. Lima, Peru, January 29, 2016.

Benton, Allyson. Research Professor at the Centro de Investigación y Docencia Económicas (CIDE). Mexico City, Mexico, July 7, 2016.

Bernal, Noelia. Assistant Professor at Universidad de Piura; former consultant at the Directorate of Economic and Social Affairs Division at MEF. Lima, Peru, November 20, 2015.

Blásquez, Jorge. Former Health Secretariat official. Mexico City, Mexico, July 19, 2016.

Bocangel, Víctor. Health Expert at the Public Budget Division at MEF. Lima, Peru, November 25, 2015.

Campillo, José. Funsalud Executive President. Mexico City, Mexico, July 4, 2016.

Candia, Alejandra. Researcher at Libertad y Desarrollo (LyD). Santiago de Chile, Chile, May 12, 2016.

Carrasco, Víctor. Professor at Universidad Peruana Cayetano Heredia. Lima, Peru, November 13, 2015.

Castiglioni, Rossana. Professor at Universidad Diego Portales. Santiago de Chile, Chile, April 6, 2016.

Castro, Julio. Former ForoSalud National Coordinator; former Dean of the Medical College. Lima, Peru, November 24, 2015.

Castro, Rodrigo. Former researcher at Libertad y Desarrollo (LyD). Santiago de Chile, Chile, April 25, 2016.

Caviedes, Rafael. President of the Isapres Association; former Executive Director of the Isapres Association; UDI member. Santiago de Chile, Chile, April 26, 2016.

Cuba, Víctor. MINSA Director. Lima, Peru, November 16, 2015.

Chanamé, César. Health Vice-Minister; former Manager at EsSalud. Lima, Peru, February 10, 2016.

Chávez, Jorge. Former PRI Deputy; former Head of Budget Control at the Treasury. Mexico City, Mexico, August 15, 2016.

Cifuentes, Pietro. Chief of the Institutional Planning Division at MINSAL. Santiago de Chile, Chile, April 11, 2016.

Cisneros, Angélica. Former Director at the Health Secretariat of Mexico City. Mexico City, Mexico, July 24, 2014.

Cortez, Rafael. Senior Economist at the World Bank's Health, Nutrition, and Population Global Practice. Lima, Peru, November 28, 2015.

De Habich, Midori. Former Health Minister of Peru; former Head of *PHRplus*, PRAES, and PolSalud, Lima, Peru, December 11, 2015.

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Flit, Michel. Manager of the Health Business Division at Pacífico; former CEO of Pacífico EPS; former Technical Director of the Peruvian Association of Insurance Companies. Lima, Peru, January 14, 2016.

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García, Pedro. Former Health Minister of Chile; PDC member. Santiago de Chile, Chile, April 13, 2016.

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Infante, Antonio. Former President of the AUGÉ Advisory Board; former Health Vice-Minister; former member of the Reform Commission. Santiago de Chile, Chile, April 12, 2016.

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Levy, Santiago. Vice President at the Inter-American Development Bank; former General Director of IMSS. Mexico City, Mexico. August 16 & September 13, 2016.

Lezana, Miguel. Director at the Comisión Nacional de Arbitraje Médico (CONAMED); former Coordinator of Advisors of the Health Secretary. Mexico City, Mexico, July 5, 2016.

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Oliva, Carlos. Director of the Central Reserve Bank of Peru; former MEF Vice-Minister. Lima, Peru, November 17, 2015.

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Paris, Enrique. President of the Medical College; former Secretary of the Medical College. Santiago de Chile, Chile, May 11, 2016.

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Ponce, Carlos. MINSA advisor; former advisor of APRA Congressman Luis Wilson. Lima, Peru, December 18, 2015.

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Rubio, Ernesto. Former President of the Board of Directors of Funsalud. Mexico City, Mexico, August 10, 2016.

Ruiz, Jorge. Advisor, Christian Popular Party (PPC); former CEO of Clínica Stella Maris; former board member of the Private Clinics Association of Peru (ACP). Lima, Peru, January 25, 2016.

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Wilson, Luis. Former APRA Congressman, President of the Health Committee. Lima, Peru, February 13, 2016.

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