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Enhancing the Political
Feasibility of Health Reform:
A Comparative Analysis of Chile,
Colombia, and Mexico

Enhancing the Political Feasibility of Health
Reform: A Comparative Analysis of Chile,
Colombia, and Mexico

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INTRODUCTION

For almost two decades now, countries in the developing world and the former socialist block have embarked on a course of governmental reform with significant consequences for their social, political, and economic spheres. While the first reform initiative of policy makers was to change the State's role in the economic sector—production, exports, market regulation, and so on—the social sector was to follow, with particular emphasis on health and education.

In health, most countries faced the need to transform their large and highly inefficient health systems which had been operating along the same policy lines for fifty years following their founding in the early post-war period. Despite important advances in the health status of many populations, there is an awareness that more could be done to remedy the pervasive problems that still remain, and to prepare to face the future challenges due to rising—and changing—demand coupled with spiraling costs.

In the face of these policy challenges and with significant influence from the international health policy arena, there is a consensus among policy makers, health providers, and users of the need for structural change in the health sector. However, there is no similar shared understanding of what the content of a health reform agenda might be. The definition of the problems to be solved, the means to solve them, as well as the speed and scope of policy change are all contentious issues, as they each affect the interests of different groups and individuals.

Health reform is therefore a highly political process, mobilizing many groups within the State and in society, whose interests may be affected by the envisioned policy changes. As a result, the political dimension of health reform formulation, legislation, and implementation has come to the foreground as it has proven to be a key factor in determining the feasibility of health policy change as well as its final outcome.

A careful analysis of the political context and the policy process within which health sector reform initiatives are formulated, legislated, and eventually implemented, can be extremely useful in the formulation of political management strategies that can markedly increase the political feasibility of reform. It can also help donor agencies and policy makers promoting health reform to fine tune their support and target it to relevant areas, thus making a more effective use of the resources directed towards initiating and consolidating health policy change.

This synthesis draws on three case studies focused on the health reform initiatives of Chile, Colombia, and Mexico. Spanning two decades since Chile's experience in the early eighties, up to Mexico's ongoing process in the late nineties, these initiatives are representative of efforts in the Latin America and Caribbean Region to face the challenge of transforming the public provision of health services. In all three cases, this process has meant the serious reconsideration of the roles the State and society are to play in providing each citizen adequate access to health care.

There are similarities in the reform agendas of all three countries, but the ultimate objectives vary according to the context in which they were implemented, and the characteristics of the policy makers who led the initiatives. Nevertheless, in spite of these differences, policy makers in all three countries faced similar obstacles, and remarkably, resorted to quite similar political strategies to try to overcome them. This study aims at characterizing these strategies and analyzing their response to the need to strengthen the political support in favor of health policy change.

The present study concentrates on the creation and use of change teams as a strategy to pursue health reforms in light of the political economy challenges presented by the context in which policy change is to take place. This strategic choice is part of an overall strategy or set of strategies that includes:

- Organizing support for health reform at the presidency, cabinet, and in the planning and finance ministries as well as the ministry of health;
- Recruiting a technically competent “change team” with both vertical links to high-level officials and horizontal links to other sectors;
- Developing sound technical arguments for reform based on reliable and credible data;
- Isolating the change team during the policy formulation stage to create a single, coherent reform package.

In order to carry out the comparative analysis, a shared factor in all three cases was selected and analyzed. This particular issue has to do with opening the possibility for the private sector to participate in the provision of health care and the management of health care funds previously under the exclusive responsibility of government agencies, such as the Ministry of health or national social security schemes.

Both Chile and Colombia have managed to achieve remarkable changes in this aspect. The level of change attempted—and to some degree attained—in these two cases has captured the attention of the international health community. However, it would not be possible to assert, in either case, that the initial objectives were totally achieved as planned. In the case of Chile, it appears that the political economy context was the determinant factor in limiting the possibilities of implementing the health reform agenda in full. In the case of Colombia, it can be argued that it is still very much an ongoing process. And last in this continuum, is Mexico. While sharing similar objectives with Chile and Colombia, it lags behind not only because it is the latest process to start, but because it is a good example of the degree of politicization a health reform may entail, and thus the formidable challenges that policy makers face when attempting it.

This study contends that while the importance of the challenging technical complexities behind a policy change of this nature are not to be underestimated, the main factor determining the degree to which reforms are accomplished is political in nature. Thus, it fundamentally has to do with the interplay of the different actors involved, their potential to influence the process, and the strategies used by reformers to pursue their reform agenda. This study brings to the foreground the relevance of the political dimension of health reforms. Our goal is to provide insight for other ongoing reform efforts in the LAC Region that, in spite of the differences in their agendas, are facing similar political challenges and having to take similar decisions for action.

The paper is divided in five sections. Section 1 presents a brief overview of the current knowledge and research in the field. Section 2 is the analytical framework that was used in the three case studies, followed by a brief discussion of the methods used. Section 3 is a succinct overview of the three cases under study. Section 4 presents the main findings of the analysis of the three case studies. Section 5 presents the conclusions and an overall assessment of the use of change teams as a political strategy for health reform. The final section includes suggested guidelines for strategies for reform in the health sector.

I. REVIEW OF CURRENT KNOWLEDGE AND RESEARCH

HEALTH REFORMS

An increasing number of countries have incorporated health sector reforms in their policy agendas as they attempt to improve the health status of their populations while at the same time maintaining or reducing their public expenditure (OECD, 1995,1992; World Bank, 1993; Walt, 1994; Frenk et al., 1994; Berman et al., 1995; Walt and Gilson, 1995). In some instances, these reforms have had an important component of income redistribution, as they have tried to redress imbalances in access to health services and in the distribution of health resources (World Bank, 1993; Frenk et al., 1994; Ugalde, 1995; Zwi and Mills, 1995). In yet others, concern with the financial sustainability of existing health systems has dominated the health reform agenda.

Health care reforms have varied in content and scope, but they share certain common features. Most involve changes in the institutional configuration of the health care system, in the role of the public and the private sector, and ultimately, in the nature and amount of services accessible to different groups of the population (La Forgia, 1994; Berman et al., 1995).

In developing countries, health reform efforts in the last decade have centered around four main concepts or principles. These include: 1) the separation of financing and provision of health services, 2) the introduction of cost-effectiveness analysis to establish policy priorities and resource allocation, 3) the introduction of user fees and expansion of compulsory insurance, and 4) the growth of the private sector's role in areas previously considered the exclusive jurisdiction of the State (Zwi and Mills, 1995).

Health reforms involving institutional change have included the decentralization of policy decision making and resource management to the sub-regional and local levels (Lee and Mills, 1982; La Forgia, 1994; Bossert, 1995) and institutional changes involved in the modernization of the State (Grindle, 1996).

Reformers have based the re-configuration of their health care systems on two major changes. One is the creation of new actors or organizations—mainly in the private sector—that are to assume roles and responsibilities, such as the provision and articulation of health care services under a new scheme of collaboration between the private and the public sector. The other is the transformation of the old actors, or existing public institutions, so they may operate under the new rules of the game (Frenk et al., 1994; Londoño, 1996; Frenk and Londoño, 1998).

In the cases analyzed in this study, reformers considered the creation of new actors, and the transformation of old ones as concomitant conditions for consolidating their health care sector reforms. Policy choice on this matter only varied with respect to the priority given to either of these two challenges, as well as in the choice of timing for their implementation. As analyzed below in detail, these choices are made according to the vision and the assumptions made by reformers, in light of the political obstacles and opportunities they encounter during the reform process. From this perspective, the successful implementation of either of these two initiatives with the absence or partial implementation of the other, can only be seen as the completion of one phase in the long and multi-linear process towards health reform, and not as the successful completion of the latter.

POLITICS AND THE HEALTH REFORM PROCESS

In spite of the fact that health reform initiatives have been converging—creating a new paradigm (Chernichovsky, 1995)—and display striking similarities in the objectives they seek, the passage of reforms through the political process has generated different results. In some cases, reforms have encountered effective resistance, as in the 1994 reform efforts in the United States (Skocpol, 1995; Steinmo, 1995). In others, such as Chile’s reform, the experience has proven so effective in bringing about change that it has encouraged other countries in the Region to follow along similar lines (World Development Report, 1993; Jimenez de la Jara and Bossert, 1995). But in most cases, the passage of health reform initiatives through the political process, has generated mixed outcomes; bringing about positive changes in some aspects of the health system, while faltering in others.

In reaction to these experiences, policy makers and donor agencies who, until very recently, had been mostly concerned with the technical soundness of health reform initiatives, have come to acknowledge the role of politics in the health reform process. They are beginning to acknowledge that politics is pervasive and that it exerts considerable influence on the objectives that are sought, the means that are used to attain them, and the resulting impact on the health status of the population. Thus, health sector reform contents are now starting to be viewed as much as the result of the political economy surrounding the policy process itself, as of the epidemiological, economic, and organizational considerations embedded in its content (Walt and Gilson, 1995).

Thus far the majority of studies on health politics have concentrated on the analysis of groups in society—called stakeholders or **interest groups**—who, perceiving that their interests may be affected, try to influence the policy process in which health reforms are formulated and implemented (Reich, 1994, 1995; Diderichsen, 1995; Makison, 1992; Blumenthal, 1992; Blendon and Mollya, 1995). A few studies have analyzed the **political institutions** that structure the health reform process, and their effect on the capacity of interest groups to effectively influence it (Dohler, 1995; Skocpol, 1995, 1992; Steinmo and Watts, 1995; Cassels, 1995; Smith, 1993; Immergut, 1992). Finally, there is a set of studies on policy change in other public sectors that has focused on the individual reformers themselves—the **change team** (Schneider, 1991; Waterbury, 1992; Geddes, 1994; Evans, 1995). This approach has great potential for the analysis of health reform initiatives, since an increasing number of countries are resorting to this policy strategy—creating and empowering change teams—to pursue health policy change.

INTEREST GROUPS AND THE HEALTH REFORM PROCESS

Health policy analysis has often considered the political factor of health reforms along the lines of interest group politics in what Morone (1994) describes as “pluralistic calculations: ‘groups for’ versus ‘groups against’”(Morone, 1994:223)¹. In this view, the formulation, legislation, implementation, and ultimately the outcome of health reforms, reflect the political

¹The pluralist school—and within it, interest group or stakeholder analysis—has best captured the dynamics of the bargaining process among different interest groups trying to influence the policy process, and between these groups and policy makers (Kingdom, 1995; Zajac, 1995; Lindblom et al., 1993; Lindblom, 1988; Olson, 1982, 1965; Wilson, 1980; Peltzman, 1976; Lowi, 1972; Dhal, 1961; Downs, 1972). The pluralist school sees the State as a neutral actor that mediates and reflects the political bargaining among interest groups who are trying to influence the policy arena in order to secure and enhance their own interest (Olson, 1982).

pressures from the groups affected by it—such as users, providers, taxpayers, and others. The health reform outcome can thus be expected to reflect the interests of the most powerful interest groups and/or the weightiest political coalition (Diderichsen, 1995; OECD, 1995; Reich, 1994, 1995; Walt and Gilson, 1995; La Forgia, 1993; World Bank, 1993).

While interest group analysis allows us to understand the dynamics of policy reform politics, it offers few answers in the cases where policy makers have decided to continue to support a reform in spite of visible resistance from powerful social groups. A closer look at the limitations and opportunities offered by the institutional context within which these policy makers pursue their reform agenda presents a more complete picture of the political factors affecting policy change.

THE INSTITUTIONAL CONTEXT AND THE HEALTH REFORM PROCESS

In order to understand the opportunities and constraints faced by health policy reformers, some studies have shifted their attention away from interest groups in society and concentrated on the role of political institutions. Their focus has been on the role of institutions in the interplay among stakeholders, as well as in their mediation between the State and society that takes place during the policy process². The institutional context, in this approach, is comprised of the national political system and the formal institutions of government and social representation. But the approach also focuses on the rules of governance—both formal and informal—that direct the policy process and mediate the conflicting views and agendas of political actors ranging from single citizens, to interest groups and policy makers among others (Immergut, 1992). The underlying assumption is that a country's institutional setting sets the ground rules for political competition, thereby determining the degree of access interest groups have to influence the reform agenda. By the same token, institutions determine the room for maneuver available to reformers, and thus the degree of autonomy the State counts on to promote policy change. In this view, a country's political economy context, and particularly its institutional configuration—with both its formal and informal elements—play a determinant role in the nature of health reform and its political feasibility.

Immergut (1992), for instance, argues that different political institutional arrangements can explain the striking differences in the final outcomes of similar health reform initiatives promoted in Switzerland, France, and Sweden. In studying the politics of social policy in the United States, and later on, reacting to the failure of the health reform efforts in the 1990s, Skocpol (1992, 1995) has also placed institutions at the center of her analysis. The importance given to institutions in the political analysis of health reform has been echoed by other scholars, such as Morone (1994), who contends that the recent failure of the U.S. health reform attempt is due in part to the lack of a careful institutional analysis. After a historical review of health reform efforts in the U.S., Steinmo and Watts (1995) concluded that a political strategy including

² New institutionalism provides an alternative approach to pluralism by addressing the institutional influence on policy making. It brings the State back into the political analysis of policy making (Evans et al., 1985) and sees policy makers as yet another interest group with particular preferences that go beyond income maximization and remaining in power, and assume a position about the direction public policy should take (Geddes, 1994; Steinmo, 1992; Hall, 1986; Skocpol, 1985; Mann, 1984; Nordlinger, 1981). Instead of analyzing formal institutions as the old statist scholars did, the new institutionalism school focuses on "how a given institutional configuration shapes political interactions" (Thelen et al., 1992:6). Thus, the focus is not on institutions *per se*, but on institutional features, or "intermediate-level institutional factors (such as) corporatist arrangements, policy networks linking economic groups to the State bureaucracy, party structures, and the role they play in defining the constellation of incentives and constraints faced by political actors in different national contexts" (Thelen et al., 1992:6).

the use and modification of the institutional setting would have enhanced the chances of health policy reform.

Finally, in other industrialized countries,³ Wilsford (1995), after examining the cases of Germany, Japan, Canada, and Great Britain, concluded that to succeed in reforming their health care systems, policy makers have tried to increase State autonomy in order to counter the interest group mobilization of providers, and that they have done so by carefully using the opportunities offered by each country's particular institutional setting. Thus, he argues that State autonomy in the process of health reform is as much a result of the institutional framework, as it is a product of the policy makers who are leading the process.

However, relating the institutional framework to the outcome of policy reform is not as self-evident as it may appear. Studying different political regimes in Latin America, Remmer (1990) showed that there did not seem to be any empirical relation between type of political regime and the State's capacity to promote policy change. Also, the content of policy reform cannot be automatically associated with a specific institutional configuration. This means that the analysis of the political feasibility of reforming the health sector needs to go beyond the institutional configuration of the country and look at the dynamics of the political process in which health reforms are immersed.

The distributional outcome of health reforms is a case in point. Interest group studies tend to show that in a democratic regime there is a high possibility of powerful interest groups capturing the State⁴, and thus perpetuating an inequitable *status quo*. However, there have been instances in which these same democratic institutions have given greater access to politically weak groups who have thus been able to influence policy in their favor by exerting political pressure to increase the government's incentives to confront the interest group coalition resisting change.

This demonstrates the need to focus the analysis on the group of policy makers in charge of policy reform, since this is where the political elements affecting the formulation of health policy converge. Their profiles, their agenda, their potential for maneuvering within the State, their relations with other groups in society will play a significant role in the State's capacity to bring about policy change. In Geddes' words: "To understand why governments sometimes undertake radical and risky reforms, scholars need to think about who the people are who make policies, what their interests are, and what shapes their interests." (Geddes, 1995:198).

CHANGE TEAMS AND THE HEALTH REFORM PROCESS

The particular group of policy makers in charge of formulating and promoting policy change has been referred to as a "change team" (Waterbury, 1992) and has been the subject of several political economy studies on policy change—particularly related to structural adjustment and

³ Other studies using the institutionalist approach to analyze health reforms in industrialized countries are Dohler, 1995; Schut, 1995; Freddi, 1989; Ferrara, 1989; Wilsford, 1989 and Bjorkman, 1989.

⁴ The concept of "capture" refers to the possibility of having powerful interest groups consolidate their influence on the State and thus bending public policy permanently in their favor. See Olson, 1982; Sandler, 1992).

economic reform (Nelson, 1990, Schneider, 1991; Evans, 1982; Geddes, 1994)⁵. The underlying assumption of these studies is that policy makers have a policy agenda that is not solely based on pressures from interest groups in society. Similarly, the State ceases to be seen as a monolithic actor with a single position about what is to be done; rather, it is seen to be composed of multiple groups of policy makers with different—and in many cases competing—ideas about what ought to be done.

The act of creating a change team, empowering it, and placing it in a position to lead a reform process can be considered as a strategy in and of itself. A government resorts to this strategy as a means of augmenting its autonomy from interest group pressure—both within and outside the State—and thus enhancing its chances of bringing about policy change. In resorting to the creation and use of a change team, the government enables the use of a series of political maneuvers geared at enhancing the political feasibility of its reform agenda. These maneuvers are the strategies that the change teams themselves choose and put into action throughout the reform process in order to facilitate its successful implementation

In the case of health reform, the change team faces pressure and competition for access to the health reform process from *within* the State, as much as from outside groups in society. Just as the State needs to gain the support of a large coalition of interest groups in society to bring about policy reform, the change team needs to win the support or, at the very least, to neutralize the resistance of other factions within the government, such as policy makers in other sectors and the bureaucracy.

The change team can be located in different points of the policy context, depending on the institutional framework of the country (Downs, 1964; Schneider, 1991; Geddes, 1994), and it may be active at several stages of the policy reform process. For instance, in a presidential system, the change team may act as an advisory committee close to the executive power, while in a parliamentary system it might be found in a congressional commission in charge of writing a bill for Congress. In yet other countries, the change team can be a formal part of the civil service, in the form of a planning commission, an *ad hoc* inter-agency task force, or an advisory group.

The analysis of the distinctive features of change teams, their composition, the background and networks of their members, and their incentives, is a key element in understanding reform processes. Also, the analysis of the opportunities and limitations these groups face in pursuing their reform agenda, and the political strategies they use in response, can provide an invaluable body of knowledge to inform policy advice in support of health sector reform.

THE HEALTH REFORM PROCESS

The policy process is the series of events that a reform initiative follows from the definition of the problem and its incorporation into the public agenda, to the consolidation of the intended policy change. The policy process rarely takes a sequential and unilinear form, but for analytical

⁵ Stemming from the schools of rational choice (see Riker, 1990) and the study of bureaucratic politics (see Downs, 1967) respectively, Geddes (1994) and Schneider (1991) focus on the political struggle that takes place within the State as different groups of policy makers compete to influence policy definition and implementation. Their basic argument is that to explain how and why a policy is formulated and what impact it has, the analysis should focus on the individual decisions taken by policy makers within the State, as well as their political competition within the limits of the institutions they operate in. The State is seen as a collection of self-interested individuals, and policy choice as a result of these policy makers' maximizing strategy in furthering their agenda. In other words, policy makers as rational individuals, will make policy decisions based on the limitations and opportunities they perceive to pursue their policy agenda—and thus secure a successful career (Geddes, 1994).

purposes, it may be ‘anchored’ in six crucial stages: 1) problem definition, 2) policy formulation, 3) policy legislation, 4) policy implementation, 5) institutional change, and 6) reform consolidation.⁶

As the policy process develops within the institutional framework of the country, the reform will pass through a number of points in which its substance may be altered, and even the very chance of it being implemented at all may be put at risk. These crucial stages of the policy process occur at different points in the institutional framework, such as the President’s office, the Congress, or the part of the bureaucracy in charge of its implementation. At each of these “policy nodes” (Immergut, 1992) or veto points, the reform will be affected by those actors who have access to these points and can influence the policy process during that particular stage. The actors that participate in decision-making at each policy node, as well as those who manage to influence them, are not the same at each stage. Also, the same actors may have different roles at the different stages of the policy process. Their agenda and their power will be different at each veto point, and their potential to influence the content of the reform as well as its feasibility will vary accordingly.⁷

⁶ See Wildavsky (1972), Lindblom (1983), Rondinelli (1984), Korten (1976) among others for definitions and characterisations of the policy process. See also Reich (1994) and Foltz (1995) for critiques of different approaches to the politics of the health policy process.

⁷ One policy analysis tool that has been developed to “map out” these actors and their interests in order to make health reform formulation, legislation, and implementation more responsive to the political challenges it faces at each stage is PolicyMaker (Reich, 1994)

II. ANALYTICAL FRAMEWORK

The present study focuses on the State's capacity to successfully bring about health policy reform. It concentrates on the elements that enhance the political feasibility of formulating, implementing, and consolidating health policy change. The working hypothesis is that the State's capacity to bring about policy change, and thus the political feasibility of health reform, is affected by three elements: 1) the political economy context of the country, including its institutions, its rules of governance, and its key interest groups; 2) the policy process, including State-society relations, and policy makers and the interest groups acting within the political context to pursue their policy agendas; and 3) the political strategies used by the reformers to secure policy change.⁸ The emphasis is on the creation and empowerment of change teams as the instrumental aspect of these strategies.

When a health reform initiative reaches the public agenda, the country's political economy and the policy process that is unleashed within it present a series of opportunities and obstacles for its successful implementation. Policy makers interested in promoting the reform will follow a series of political strategies in order to enhance the State's capacity to bring about policy change, and thus increase the political feasibility of the health reform.

As policy makers turned to the social sector in second-generation reforms, they shaped their political strategies taking into account the knowledge acquired during their experience with first-generation reforms aimed at restructuring the economic sector and downsizing the State under structural adjustment in the 1980s and early 1990s.⁹ One salient strategy is the formation and use of change teams to formulate policy and direct the reform process. Thus, we pay particular attention to this as part of the package of political strategies aimed by policy makers at enhancing the political feasibility of health reform initiatives.¹⁰

The opportunities and limitations presented by the political economy of the country and the policy process on the one hand, and the State's response to them on the other, converge in this change team, that is in charge of formulating and implementing the reform. The ability of these policy makers to maneuver within this setting has a direct impact on, and reflects the State's capacity to pursue its agenda on health policy reform.

The change team uses a combination of technical skills and political maneuvering to build support for the reform initiative and enhance the probability of successfully challenging interest group resistance to change. The change team's capacity for strategic political maneuvering during the health reform process will prove as determinant to its accomplishment, as the team's technical capacity to formulate sound policy.

⁸ There are other elements that are equally important in determining the State's capacity to bring about policy reform. Grindle (1996) suggests concentrating on the following elements: institutional capacity, technical capacity, administrative capacity, and political capacity. In other studies, State capacity has often been equated to its technical, administrative, and institutional capacities, while its political capability to maneuver in favor of policy change has only recently been brought to the fore in the health policy field. Therefore, this study is concentrating on the political aspect of the State's capacity to pursue health reform in an attempt to contribute to putting in place the elements that effectively promote health policy change. However, it is important to note that the political component is not sufficient, nor can it be analyzed in isolation from the other elements cited above.

⁹ For more on the political economy of first generation reforms and the use of change teams as a strategy to bring about change, please see Smith (1993); Bresser Pereira, Maravall and Przeworski (1993); Haggard and Kaufman (eds) (1992); and Grindle and Thomas (1991) among others.

¹⁰ See Walt (1994)

The analytical framework used for this study looks at 1) the political economy context, 2) the policy process, and 3) the reformer’s political strategies as three variables affecting the State’s capacity to bring about health policy reform. This framework has allowed for a more systematic observation of the intervening factors determining the political feasibility of health policy change and facilitated comparative analysis. This, in turn, has enabled us to analyze important elements common to all three cases; variables that may prove valuable in analyzing other health reform experiences.

Table 1. The Political Economy of Health Sector Reform General Framework

I. POLITICAL ECONOMY CONTEXT	II. POLICY PROCESS	III. POLITICAL STRATEGIES: CHANGE TEAMS
<ul style="list-style-type: none"> • INSTITUTIONAL CONFIGURATION • REGIME • FORMAL ATTRIBUTIONS OF RELEVANT INSTITUTIONS AND ACTORS • FORMAL RULES (INSTITUTIONAL FEATURES); I.E., ELECTORAL CYCLES, ETC. • INFORMAL RULES (INFORMAL INSTITUTIONAL FEATURES); I.E., WEIGHT OF PARTY DISCIPLINE OVER POLICY MAKERS ONCE IN OFFICE, SOURCE OF STATE’S LEGITIMACY, ETC. • GENERAL POLITICAL MAP OF KEY PLAYERS; I.E., GOVERNORS, ELITE GROUPS, KEY INTEREST GROUPS, INTERNATIONAL DONORS AND MULTILATERAL AGENCIES INVOLVED, ETC. 	<ul style="list-style-type: none"> • ANCHOR STAGES OF POLICY PROCESS PROBLEM DEFINITION POLICY FORMULATION POLICY LEGISLATION POLICY IMPLEMENTATION INSTITUTIONAL CHANGE REFORM CONSOLIDATION • KEY POLICY NODES/ARENAS WHERE REFORM MAY BE SIGNIFICANTLY ALTERED, INVIGORATED ,OR HALTED; I.E., MOMENT OF PASSING LEGISLATION, ETC. (TIME AND PLACE) • RELEVANT ACTORS IN KEY POLICY NODES • INTEREST GROUP REPRESENTATION IN POLICY DEBATE AND STATE-SOCIETY RELATIONS 	<ul style="list-style-type: none"> • USE OF CHANGE TEAMS AS A POLITICAL STRATEGY . • CHANGE TEAM CHARACTERISTICS: CONFIGURATION LOCATION EXPERTISE PREVIOUS POLICY EXPERIENCE • CHANGE TEAM POLITICAL MANEUVERING: VERTICAL NETWORKS WITHIN THE STATE HORIZONTAL NETWORKS WITHIN THE STATE POLICY NETWORKS ACROSS STATE-SOCIETY . • RELATED POLICY STRATEGIES: INSULATION VS. CONSENSUS- BUILDING. INCREMENTAL VS COMPREHENSIVE

POLITICAL ECONOMY CONTEXT

The political economy context includes the political system of the country, its recent history, its socioeconomic conditions, its institutions, and the role of the State and society in defining and acting upon policy issues. It sets out the institutional framework within which policy makers and

interest groups operate during the policy process and it presents the formal and informal rules of the game within which policy makers and interest groups pursue their agendas.

Policy makers willing to promote reforms that will benefit some groups while negatively affecting others will take into consideration the interests and power of stakeholders who might step up in favor of or against policy change. Sociological studies have concluded that powerful interest groups can “capture” the State, leading reformers to reformulate their policy initiative and even to stop a policy change in spite of its technical soundness and potential for enhancing the common good. However, experience in first-generation reforms under structural adjustment shows that reformers were able to pursue and accomplish significant policy changes—like trade liberalization and market deregulation—even at the expense of powerful actors defending the *status quo*. What explains this?

One possible explanation may lie in the political institutions structuring State-society relations. The political system and its institutions establish the “rules of the game” by which policy makers and social actors pursue their agendas. In laying the ground for the policy process to evolve, and therefore for the political struggle aimed at influencing it, political institutions play a determinant role in empowering some actors over others in and outside the State. Therefore, the political feasibility of a reform initiative will be determined both by elements from interest group politics, as well as the shape and role of the existing political institutions.

POLICY PROCESS

The policy process is the series of events that a reform initiative follows from the definition of the problem and its incorporation in the public agenda, to the consolidation of the intended policy change. It is analyzed in its six anchor stages: problem definition, policy formulation, policy legislation, policy implementation, institutional change, and reform consolidation.

Policy makers will use the institutional framework of the political system to the reform’s advantage in an effort to limit the influence of those actors that are against the reform initiative. For instance, it has been argued that political systems with a strong Executive power—i.e., with constitutional prerogatives allowing it to govern without subjecting policy initiatives to the concurrence of the Legislative and the Judiciary—are better able to isolate policy formulation from interest group politics. This, in its turn, would seem to enhance the political feasibility of the policy reform initiative and to facilitate a speedier implementation.

However, circumventing the channels for interest representation and limiting the access of actors within and outside the State to policy formulation, may not necessarily enhance the chances of the reform’s survival and consolidation. The politics that are suppressed by these means at the policy formulation stage, and that are not dealt with during the legislation process, may simply resurface at the implementation stage and require consensus-building and the pursuit of coalition strategies to ensure the political feasibility of the reform.

The lack of regular use of interest representation mechanisms in reform formulation—such as the Congress and political parties—, also contributes to transferring political conflict over policy debate from the wider social arena to a narrower one within the State. Here, bureaucratic politics assume greater significance and different factions of policy makers confront each other representing a wide array of views and ideologies in the political spectrum. Even in the cases where interest representation was avoided, and the center of debate was thus transferred to within the State, policy reform still required intense political maneuvering, as different State factions struggled over policy options to be implemented.

The fact that the locus of competition for different reform projects is forced away from the formal channels of interest representation and into the Executive arena does not completely prevent interest group participation in the struggle. Instead, participation is significantly limited and is shaped in a different manner than is the case when it is pursued in an open arena such as Congress. This phenomenon is rooted in the initiatives of policy makers on the side of the State, and interest groups on the side of society. Interest groups have become aware through knowledge of the political dynamics of other reforms, that the veto point that will define the nature of policy change is within the Executive and not in Congress. Thus, they will gravitate to the former. But, they will do so by resorting to informal channels and elite contacts that will give them access to key decision makers.

On the other hand, decision makers who are competing to have their particular reform project prevail, will certainly try to avoid the influence of those interest groups that oppose it, while seeking and nurturing links with those interest groups that favor their proposal. This is one way to enhance their position of power vis a vis other State factions. The study labels the resulting alliances “State-society networks” and assumes that these can be clearly distinguished during reform formulation aligned around the competing reform proposals.

In first-generation reform experiences involving market regulation and other aspects of the economy, those policy makers who were able to circumvent interest representation mechanisms on the grounds that these were captured by powerful vested interests—for instance resorting to Executive decrees instead of legislation—seem to have been successful in consolidating policy change. On the other hand, those policy makers who emphasized interest group participation and consensus-building through institutional representation channels such as Congress seem to have had their initiatives deadlocked and effectively derailed. However, in second-generation reforms, when the first strategy was attempted, it seems that the lack of participation and consensus-building with provider groups during the reforms’ formulation and legislation, has been an important hurdle for implementation. Yet, it remains an open question whether the systematic use of consensus-building and participation has improved the chances of bringing about reform implementation, given that the current state of most health systems is such that *pro status quo* interests will necessarily be negatively affected. Also, support coalitions are volatile and agreements fragile.

While market reform was basically about changing rules and incentives, and diminishing the size of the State, second-generation reforms such as health policy change not only have an incentives and regulation component, but depend on many provider groups whose behavior needs to be transformed in order to consolidate policy change. For instance, even with a more significant participation of the private sector, the State will still have to rely on a large group of salaried health workers and managers in order to deliver better health services. Effectively bringing these groups on board the health reform process will probably require political strategies that go beyond surprise changes of incentives and regulations, since contrary to what happens with market actors, the State’s capacity to transform its health services depends on consensual changes in behavior. What are policy makers’ decisions when faced with the need for consensus-building or confrontation with these groups?

The distinction between these two challenges is reflected along the lines of the two main groups of actors involved in health provision. “Old actors” are agencies that have been in charge of public health service delivery and that would be transformed under a reform initiative. In this case, the major task is the transformation of the salaried health manpower involved. “New actors” are those private provider organizations that are created and/or regulated under new legislation and that respond to market incentives. In this case, the major challenge is creating the

market conditions that will allow for their development, while at the same time protecting the interests of the potential beneficiaries.¹¹

Along the same lines, another important point to be taken into consideration is at what stage of the policy process does opposition to a reform peak, and how do policy makers pursuing change deal with it. The argument has been made that the technocratic approach of isolating reform formulation from interest groups leads to excessive and some times paralyzing politicization during a reform's implementation stage. But this argument fails to take into account that groups opposing policy change also choose the most opportune moments in which to flex their muscle. This is particularly important in second-generation reforms such as health, where the State depends largely on its bureaucracy to bring about change. Such may be the case of unions and other provider groups within the State. While they may effectively be kept from participating in reform formulation, they might also choose not to act at that stage. Instead, they might pursue more active strategies during reform legislation, when reformers are forced by the institutional rules to "open" the process. But the negotiating power of unions and provider groups will become strongest during reform implementation, when policy change will depend on them. Thus, these interest groups against change may choose to press their demands and attempt to halt the reform process at that stage, regardless of the strategy used by reformers in the prior stages.

Finally, given that the ultimate goal of a health reform is to change health services in order to have a positive impact on the health status of the population, how does the population at large respond to the potential effects of policy change—both negative and positive—on its interests? One of the key factors affecting this issue brings us back to the political context in which the health reform is taking place. The degree to which the majority of the population assumes and is aware of its rights and responsibilities as citizens is a major factor in the manner in which society will demand access to health care services, be concerned with the quality of the services, and support changes in this direction. By the same token, a social group's clarity about its right to have access to a package of health services will also reflect on its potential for mobilization against a reform that in its view might limit this access to health care.

This is of particular relevance in the case of reforms that entail redistribution in which those with privileged access to health care will cease to have unlimited access, while those who did not have access at all will have a minimum package of services available to them. Generally, the former groups are organized and aware of their benefits, whereas the later are not politically organized and are not aware of their right to health care. The resulting challenge for the political feasibility of such changes needs careful attention and strategic management.

CHANGE TEAMS AND OTHER POLITICAL STRATEGIES

A central element of the reformers' political strategies aimed at buttressing the State's capacity to promote policy reform is the creation and use of change teams empowered to bring about policy change. The change team is the point where most of the reform efforts as well as political pressures to affect the reform process converge. Its characteristics, its ascribed power, and its location will determine its capacity for political maneuvering within the State and its

¹¹ An example of old actors would be the health services provided by social security through its own facilities, or the services provided by the Ministry of Health under the same scheme. An example of new actors would be the health management organizations (HMOs) of recent creation and/ or expansion in the countries under study.

ability to gain support in favor of policy change across State and society lines. The change team's ability to draw up and pursue an effective political strategy in favor of policy reform will have a great impact in the State's capacity to bring about change, and therefore in the political feasibility of its reform agenda.

By the same token, the capacity of these policy makers to operate will depend on their choice of political strategies to enhance the political feasibility of their health reform initiative. One strategy focuses on empowering and maintaining the change team embedded in the institutional context in which the reform process is taking place. Then there are the strategies that the change team itself will adopt in favor of its reform agenda.

Experience in first-generation reforms showed that reformers were able to "manage" interest group pressure to influence the policy process by conveying support in favor of policy change when needed, while at the same time limiting the level of influence of vested interests in the *status quo*. The use of highly technical skills in policy formulation allowed them to keep tighter control over access to the policy process, while at the same time allowing them to fine tune the policy reform package according to mostly technical and strategic criteria, instead of political considerations.

Other strategies used by reformers to pursue policy change have been one-time comprehensive policy change, as opposed to an incremental approach to policy implementation, thus leaving very little time and scope for organized resistance. This involves a minimum of consultation and consensus-building—tending to inform more than to ask, except when there is a perceived need for coalition-building. There is no clear political strategy when policy reform needs the active and consensual participation of other actors, such as the bureaucracy, provider groups, and/or particular interest groups. As a consequence, mixed results have been obtained when policy reform contemplates not only downsizing the State, but transforming it.

The very mixed results that have been obtained thus far by reformers and their political strategies in the case of second-generation reforms are of special interest for this study, since health policy reforms do need the collaborative participation of several actors involved in the provision of health care, both within and outside the State, in order to succeed.

While at first glance this scenario might suggest a policy recommendation calling for a more participatory and consensus-building approach—and indeed, the scarce literature on the subject is inclined towards this view;¹² a more careful analysis needs to be done in order to avoid oversimplified policy advice. Prioritizing consensus-building and participation may simply reinforce the State's capture by vested interests, such as the bureaucracy and organized labor, who have effectively derailed any attempts at policy change in the past to the detriment of unorganized users. Also, unmanaged participation has led to policy deadlock bringing reform initiatives to a halt, instead of ameliorating their substance.

On the other hand, calling for an exclusionary process with a small team of experts empowered to conduct a health reform with little accountability to any other group is not the immediate answer to the previous scenario. More research needs to be done in order to single out the range of options in designing the political strategy that fall between these two extremes in order to effectively enhance the political feasibility of health sector reform without sacrificing the participation of State and society actors.

This raises the issue of a change team's empowerment to pursue health reform. A change team's mandate does not stem from society, since none of its members hold electoral positions.

¹² For more on this literature please see Section I on Current Knowledge and Research in the section on Interest Groups and the Health Reform Process.

Rather, it stems from senior policy makers who have decided to resort to a change team as a strategy to bring about policy change. Thus, a change team's source of power does not stem from a direct mandate from society, but rather from the systematic support of these senior policy makers. If such is the case, a change team is dependent on its vertical networks; that is, its links with senior policy makers in order to be able to survive as a group and to pursue health reform.

What is the nature of these vertical networks? Change team leaders in the area of health were in most cases originally junior members of the economic teams. Economic change teams form and support these policy-specific groups as a means to lead change in areas outside the economic sphere. By the same token, the majority of the members of a health change team are "outsiders" in the Ministries of Health, and doctors have very little participation in them. This would lead one to suppose that the vertical networks that create an effective health change team as opposed to a task group with no power on its own to pursue policy change, seldom stem from senior policy makers in the ministries of health. Rather, they stem from the finance and planning areas of government or even the presidency, where the economic change team is located. This connection would be in accordance to the usual pattern that State reforms have followed: first-generation reforms concentrating on the economic sphere followed by second-generation reforms such as health.

This study focuses on discovering the opportunities and obstacles in the political economy context that a health reform initiative will encounter as the policy process evolves. It then assesses the political strategies that have been used to respond to these challenges and opportunities. Finally, it presents a series of analytical elements for the assessment of the political context affecting health policy change during the reform's process and the performance of change teams as a political strategy.

METHODS

The present study employs a comparative institutional approach (Evans, 1995). It is institutional in that it focused on how and why policy makers interact with the institutional constraints and opportunities present in the political economy context, and relates these findings to the political feasibility of health policy change. It is comparative in that it looks for variations in similar policy reform processes as the basis to understand the relevant elements determining the political feasibility of health sector reform.

The research was carried out in following sequence. First, secondary sources such as scholarly accounts about the political economy of the countries under study were gathered and analyzed. Then primary sources such as official documents, and statistical evidence were collected and drawn upon to complete and complement the previous research on each country's policy process. Finally, unstructured key informant interviews were conducted in order to obtain information on the actors involved in health reform, their characteristics, their perceptions about their mission, and the obstacles and opportunities they found in the pursuance of their agenda.

The countries in the three case studies (Chile, Colombia, and Mexico) were selected on the grounds that their reform agendas all shared the reconsideration of the role of the State and of the market in the provision health services and the management of health funds. As a result, all three countries envisioned the introduction of a plurality of new actors that, under market mechanisms and State-regulation, would share responsibility for health provision with State agencies. This would radically transform the health systems that had been operating as State services since the beginning of the post-war era. Taking this policy tracer as the point of comparison, three elements were analyzed in each country: the political economy context, the

policy process, and the policy makers that led the reform initiatives. Research took approximately six months in each country with the help of a team of local consultants with expertise in political economy, health policy, and economics. The key component was the series of interviews with key informants, including academics, policy makers, and other relevant actors, including members of the change team itself. An in—country seminar presenting a first draft with preliminary results was organized in each country with the invited participation of all individuals interviewed as well as other actors of the health sector, in order to present and discuss the results of the analysis.

The selected country cases were used to probe the working hypothesis on the political economy of health sector reform and the factors influencing its political feasibility. This was done by preparing a detailed characterization of the policy choices the reformers faced, and the political strategies that they used in each country. The synthesis study focuses on the elements that can support general arguments about the factors that affect the politics of the health reform process.

Focusing on change teams in all three countries has permitted the analysis of the political dynamics that take place within the State both as a reflection of State-society relations, and as a result of political competition among different groups of policy makers. Field work in the respective countries focused on the change teams' participation in and interpretation of the health reform process.

While conclusions about these particular reform processes are not statistically representative — given that only three cases were studied—they may show features that are common to other countries with similar political economy contexts and may serve as the basis for further comparative analysis.¹³

¹³ In fact, an agenda for future research in this field could assess the validity of this form of analysis in other countries in the Latin American Region, as well as other middle-income countries with comparable political economy contexts—such as some of the former socialist economies in Eastern Europe.

III. CASE STUDIES

While the change teams in charge of health reform in Chile, Colombia, and Mexico are similar in composition, ideology, political backing, and political maneuvering, the results of their political strategies have not been the same. Chile is considered to be the country in the LAC Region that has managed the most drastic transformation of its health system. Colombia has successfully started the implementation of its health reform, while Mexico has thus far attained very limited results.

The three case studies juxtaposed the similarities in the envisioned policy change related to the participation of new private sector providers as well as the political strategies used to pursue health sector reform with the differences in the results attained in each country thus far, as a means to pinpoint the relevant political economy factors that affect the reform processes. This section presents a brief description of each of the cases in chronological order. The country studies are all presented using the same analytic al framework described above in order to facilitate comparative analysis.

CHILE

The Chilean health reform implemented in the early eighties has received a great deal of attention from academics and policy makers alike. Although the fact that it took place under a military regime makes it an exception in the Region, the Chilean reform process has been emulated to some degree or another, both in process and content. Discussion about the effectiveness and appropriateness of replicating the strategies used by its team of reformers in other countries with more open political systems, has not reached a definitive conclusion. Nevertheless, these strategies continue to influence policy makers in ongoing policy processes in Latin America and elsewhere.

The main goals that the reformers attempted to achieve by implementing a system of private health plans in Chile were to release capacity in public facilities by shifting demand to the private sector; induce an expansion of the private health care infrastructure and medical services; concentrate the State's efforts on the low-income population; increase freedom to choose; and to create a demand subsidy in the long run that would allow for greater choice among health services.

The reformers were successful in achieving some of these goals, but certainly not all of them. The implementation of private insurance plans, known as ISAPRES (Instituciones de Salud Previsionales), significantly expanded private health care infrastructure in the nation. The demand for services provided by these facilities and by professionals in private practice have also increased substantially. Also, it appears that the reformers succeeded in targeting a greater proportion of fiscal resources to low-income groups. Both physical assets and operational resources are now serving a greater percentage of low-income households than in previous years.

While the reformers made some progress towards the goal of creating a demand subsidy, this part of the reform was never brought to completion. A demand subsidy was created to complement by 2% the mandatory contribution, but the use of this subsidy for its purposes has faced several problems that have been acknowledged by all sectors of the political spectrum and this aspect of the reform does not enjoy legitimacy among social actors. Finally, the attempt to

create a demand subsidy that would have created subsidized ISAPRES for those without purchasing power, was brought to a complete halt.

Furthermore, the ISAPRES attracted mostly high-income individuals who then stopped contributing to the public system and additional funds to make up for this loss were not allocated to the public facilities. Thus, the creation of a private system may have aggravated the operational deficit that the public system faced during the economic crisis of the 1980s. Since 1988, with the economic crisis under control, the data show that the reform may have released capacity and operational resources for the legal beneficiaries of the public system. If health care expenditures in the public system had stayed constant at the level of 1981, financial resources *per capita* would have increased by 13% for each beneficiary between 1981 and 1994. However, the amount of public expenditure per beneficiary was 83% more in 1994 than in 1981. Thus, it may be the case that those resources that might have migrated to the ISAPRE system during the 1980s have been compensated in the 1990s with a significant increase in fiscal funding.

Probably the most important goal for reformers was to allow beneficiaries to choose among a variety of health plans in order to introduce competition as a means of improving quality and efficiency in health care provision. This goal was partially accomplished. Enrollees who are able to afford the premiums charged by ISAPRES have many alternative health plans from which to choose and the private health industry is not highly concentrated. Thus, there is real competition among ISAPRES targeting young or middle-aged high-income groups. However, individuals over 60 years of age have almost no access to the private system, and individuals with catastrophic and chronic diseases have limited freedom to stay in the system or to change from one institution to another. Finally, information for consumers to make informed decisions when choosing health plan is very poor.

The ISAPRES currently cover 26% percent of the population, and approximately 31% of the labor force. Current enrolment exceeds any of the initial expectations. However, future expansion aimed at including the total population under a similar scheme, would require either the implementation of the originally envisioned demand subsidy that was to substitute public provision of health services, or greater efforts to reduce the premiums of the ISAPRE system, by reducing its average actuarial costs.

Political Economy Context

The study of any aspect of the various institutional, economic, and social changes which were carried out during the 1970s and 1980s in Chile needs to put at the forefront the institutional context within which these reforms were formulated and implemented. There is widespread agreement that a fundamental factor in successfully bringing about the quite sweeping reforms of the period was the fact that Chile was governed by a military regime that was able to present itself as a cohesive actor. However, the fact that the regime drastically dismantled dissent stemming from society and imposed its policy agenda, veils the very dynamic and even strenuous policy process that took place within the State apparatus itself in the pursuit of a reform agenda. While societal representation was limited to the erratic participation of those groups that sympathized with the regime, this did not stop the ongoing internal factional competition within the regime of groups with opposing views about the content and speed of the reforms.

One of the factors which contributed to this appearance of lack of disagreement within the government was the fact that the core of the resistance to the content and speed of the reforms, stemmed from some of the branches of the armed forces. The military's command and control lines, as well its members' allegiance to hierarchical obedience, made them refrain from open dissent. However, as soon as he took power, General Pinochet put in place the formal

institutional mechanisms through which the different factions of the military could express their views and participate in the process of policy making —thus guaranteeing the means through which to tap into the positions of his core base of support. In its turn, the military did resort to those institutional channels open to them to voice their position to the higher spheres of the regime. Also, if in a very low scale, some members of the military who were against the technocratic reforms did establish alliances with societal groups who, while being in favor of the regime, were not so prone to support the proposed policy change.

As it will be discussed in the next section, the majority of actors related to the health sector, and quite probably the population at large, were in agreement about the need for some sort of reform. The notion that the health sector was in disarray was a widespread assumption at the time of the formulation of the reform, thus facilitating the original impetus for change. However, this consensus around the need for change was not true when it came to defining the problems to be addressed, the means to address them and the speed at which reform should take place. Disagreement on these issues was not only evident among the various actors involved, but, most importantly, amid the various groups that composed the military government. Some groups aligning themselves around the technocrats who composed the economic team, while others supported the pro-State nationalist branches of the armed forces.

Policy Process

The health sector in Chile was subject to comprehensive reform during the late seventies and the early eighties. Among the reform initiatives was the creation of private organizations that were allowed to collect mandatory contributions for health care coverage, called ISAPRE¹⁴. The reform, passed in 1981, gave workers and pensioners the option to enroll in any ISAPRE or to stay in the public health plan (FONASA). The ISAPRES were to substitute for the public health plan in the financing and provision of health care. Initially, they were mandated to cover minimum preventive services and sick leave payments. However, benefits packages for curative care could be established through individual contracts between the parties. Formally, ISAPRES compete among each other on the basis of the benefits package each is able to offer for a similar premium.

The creation of ISAPRES was the first step of a comprehensive reform agenda that was eventually to transform the health sector into a system that would rely more on the market than on the State for the entire financial administration and provision of health care. While those income groups with purchasing power were given the option to enroll in an ISAPRE as described above, a demand subsidy was to be created and targeted exclusively to the low-income groups. For these groups, similar health management organizations called ISAPRES Populares were going to be created with the same profile and functions as the original ones. The only exception would be that premiums would be covered with public funds.

The social security reform that took place before the health reform, set a precedent as the first experience in Chile in the private delivery of social benefits. It marked the fact that mandatory contributions were the property of the employee, and that therefore, as was the case in the reformed social security system, the employee was free to choose the entity that was to manage his/her health funds. The creation of private for-profit institutions geared at managing the pension funds on a competitive market, set an important precedent for the private health insurance system that was to be created. It was expected that competition among institutions would promote efficiency and benefit those enrolled. The social security reform also separated

¹⁴ Instituciones de Salud Previsionales (Private Health Plans)

contributions for health care from those for pensions and other benefits, thus establishing the stepping stone for the creation of ISAPRES.

Among the enabling factors that contributed to the inclusion of the health reform in the public agenda, one that stands out is the regime's high political capital (or political support) in the early eighties stemming from a positive economic performance that brought a certain degree of legitimacy to the government in power. This was reinforced by the enactment of the new Constitution, which formalized the use of power as was defined by the military. The economic recovery had also brought a certain degree of stability in the public budget, opening the possibility for policy experimentation.

On the other hand, and also contributing to the regime's capacity to bring about policy change, the potential for political mobilization of important interest groups and entire segments of society had been drastically curbed. Within the health sector, such was the case of the Medical Association, other health provider associations, and all labor unions, whose activities had been severely hampered if not brought to a halt. Finally, within the State itself, the military factions who favored a larger role for the State in the health sector, and who had brought their case to the *Comité Asesor*, had lost their last battle against change by failing to deliver improved results at the National Health System (SNS) when they were put in charge of it.

Once the law was approved, the creation and launching of ISAPRES depended mostly on changes in regulation. The involvement of the bureaucracy was minimal, limited to the registration of new organizations, and the enforcement of a regulatory body that gave pre-eminence to market mechanisms for the control of the new system. This meant that policy implementation was not dependent upon bureaucratic cooperation, but on the market's response to the new actors. It was from the market, and not from organized resistance, that the most important obstacles for the reform's consolidation emerged. The evolving economic crisis created a difficult start-up process for the ISAPRES, and forced the State to intervene with last minute support and changes in regulation in order to guarantee their survival and eventual maturation.

While the ISAPRES' market eventually expanded beyond its initial target and consolidated into an important industry, policy makers failed to complete the reform of the entire health system as they had initially envisioned, by creating the ISAPRES *Populares* for the low-income groups and privatizing the public hospitals. The implementation of this second phase would have resulted in the totality of the population being enrolled under the new scheme with very few exceptions, and a new health system would have substituted the old one.

The policy makers' attempts to complete the reform by creating the ISAPRES *Populares* and privatizing public hospitals failed due to policy content factors, reformers' decisions on strategy and the political context in which these efforts were made. The reformers decided to delay the implementation of this second phase of the reform several times. This tardiness was in part a consequence of the fact that incorporating low-income groups into the new system was not given the same priority. Given the resistance that the reformers found in the health sector since the beginning, it was soon clear that the old public health system was not going to be significantly transformed and could thus cushion these groups. Also, the level of complexity required to create quasi-market mechanisms for the ISAPRES *Populares*, where the State was going to be the only funding source, presented challenges that were not solved at the detailed level needed for their implementation. The same could be argued about the initiative to privatize the public hospitals. Pilots were tried on both policy areas and failed. Furthermore, the privatization of hospitals remained controversial in policy and in political terms, requiring high levels of political capital.

The reformers chose instead to focus on consolidating ISAPRES as a showcase not only for other aspects of the health sector, but also for the delivery of other social services, notably, experiments that were conducted in education. It was expected that a more efficient service delivery conducted by the private sector under market rules, was eventually going to tilt policy preferences toward these mechanisms for health service delivery to all income groups. The successful implementation of ISAPRES was in and of itself considered part of the strategy in presenting other options for public service deliveries. From this perspective, the complexity and unpredictable performance of ISAPRES *Populares* became too large a risk to take. Little room was left for experimentation and trial and error.

When the ISAPRES *Populares* initiative was finally presented to top-level decision makers, the political economy context had dramatically changed since the initial implementation of ISAPRES. Contrary to what was the case in the early eighties, the public agenda by 1988 was entirely focused on a single crucial issue: a plebiscite in which the type of regime the Chileans wanted was at stake. Not only had the military government lost most of its political capital, but both the regime's leaders and the economic team were gearing it towards long-term, structural issues, such as making sure that the policy changes that had been implemented would be consolidated and remain in force despite the democratic transition. The technocratic team concentrated on making sure that the economic model they had put in place would not be significantly reversed. Last minute regulation to this end was also passed for the ISAPRES market. The political difficulties presented by this context forced issues such as the ISAPRES *Populares* out of the reform agenda. Also, the members of the economic team that had been successful in gathering support for various reform initiatives, were no longer in government at the time. This severely limited the economic team's ability to broker its policy agenda within the State.

Change Team and Other Political Strategies

During the military regime, a small group of highly trained economists joined the government in the top policy positions with a comprehensive reform agenda aimed at transforming both the State and the economy under the premises of a neoliberal ideology. It can be argued that the creation and use of this team by the military regime was a strategy in and of itself. It facilitated reform formulation, legislation, and implementation at the margin of the internal and—albeit limited—external political bargaining among military factions and interest groups affected by the policy changes. Upon their arrival, the economists constituted themselves as a tightly closed team that shared the same ideology and policy agenda. The team distributed the different roles needed to pursue policy change according to each member's comparative advantage—such as long-term policy formulation, the design of short-term operational policy and legislation, political brokerage, and even the recruitment of suitable policy makers. They did not pay close attention to the expertise needed to reform any particular sector.

In order to empower itself and give political feasibility to its reform agenda, the team resorted to a series of strategies aimed at embedding both the team and its project within the State. First, it established vertical networks or close and durable links with senior members of government that would give the team political backing and support its proposals against the persistent resistance of most factions of the armed forces and allied interest groups. Second, they established horizontal networks with peers and sympathizers who occupied key positions in veto points, or moments/places in which their reform agenda could be at risk. These included the president's Advisory Committee, the Legislative Commissions, and senior positions in core ministries such as Planning and Finance. Finally, once the core members of the change team had established themselves in top-level positions, the team resorted to the strategy of colonization or

a highly systematic and coordinated scheme of recruiting and placing of highly-motivated, trained professionals that shared the same ideology and mission to bring about radical change.

While the characteristics of the political economy context of the military regime nearly halted social participation in favor or against policy changes, factions for and against the reforms within the government did work to gain the support of the few groups who could still exert a certain degree of influence or at least manifest their support for one position or another. This was always done within the limits drastically established by the military regime. Thus, the change team sought and constructed links with those groups in society that either shared their ideology or benefited from the reforms' outcomes (i.e. the new business groups who were to benefit from economic liberalization and deregulation), establishing State-society networks that helped them counter the resistance to change stemming from similar networks that were *pro-status quo* (i.e. doctors and the Medical Association).

The team maintained a very close control over the reform process in different sectors through the direct involvement of its senior members, as well as an informal network that cut across the bureaucracy establishing informal command lines over junior members sent to "colonize" the sectors under reform. Some of this control was later institutionalized by putting all senior operational units—i.e. undersecretaries—under the direct supervision of the Finance Ministry. Change team members gravitated around the Planning Office (ODEPLAN) where policy was studied, formulated, and dictated. Follow-up was accomplished with the help of change team members or colonizers established in the different sectors under reform. This center of gravitation was going to move to the Finance Ministry during the second and last phase of operation of the change team or what could be considered its "come back" after the economic crisis of the early 1980s until the end of the military regime.

During the process of health reform and the creation of ISAPRES, the team resorted to a series of strategies aimed at enhancing the political feasibility of its policy agenda. Among them was the deliberate obfuscation of intended policy changes in order to avoid possible resistance at key veto points, such as the Legislative Commissions. The opposition was divided through the selective use of policy concessions affecting individual interests and compensatory measures for powerful interest groups with the potential to bring the reform to a halt—such as the armed forces. Also, throughout the reform process, the team made a systematic effort to educate and indoctrinate elite decision makers about the premises for their proposed policy changes and the ideology behind the model that was being followed. This strategy was also directed toward attention groups and the attentive public¹⁵ in society through the dissemination of their ideas and motivations via sympathetic mass media and academic and business circles.

Following its ideological precepts—freedom of choice, apolitical decision making, a residual State, among others—the change team believed it was possible to apply the model and experience of the pension system reform to the health sector. It succeeded, but only partially. While the implementation of the first part of the ISAPRE reform was successfully completed, its second phase, which was to bring about a health insurance system with universal coverage, was abruptly brought to a halt. Several factors can be considered, among others, the fact that there were technical, fiscal, and political constraints, since Chile faced a period of economic restraint

¹⁵ Attention groups are those groups in society with an interest on a particular policy issue, but who are not mobilized in order to attain it (which is the case of interest groups). An attentive public is one that pays attention to the issue by keeping itself informed of the process it is following, but does it among an array of other policy issues. Interest groups or government factions actively promoting a policy issue will direct their efforts towards informing and convincing these non-mobilised groups in order to strengthen support around it and thus give it more political weight. For more details on these concepts, see Rochefort and Cobb (eds.) (1994); and Cobb et al. (1976).

and the military regime's political capital was rapidly eroding. But also, the ISAPRE team members lacked the brokerage ability of those who had led the pension system reform—its policy brokers having abandoned the government immediately after ISAPRE initial legislation was enacted—and their efforts were tardy.

The team failed in its attempts to eliminate special interests from the sector as it had envisioned in its reform agenda. In spite of the institutional changes introduced by the team, the Medical Association recovered its power and continues to be an influential actor to this day. Also, counter to the team's ideological bearings, the health reform it promoted created other special interests that have gained considerable power over the years, including private clinics, and notably, the ISAPRES themselves. Both interest groups have successfully halted policy changes and new legislation aimed at correcting the private health insurance system, with some of these changes aimed at making it function in the way envisioned by the change team.

The strategies used by the change team and the creation of the team itself as a political strategy, were to influence policy making in succeeding administrations in Chile and elsewhere in the Latin American Region. The democratic government that was to follow the end of the military regime resorted to a similar strategy to continue the health reform by creating a change team with highly qualified professionals empowered to bypass most of the sector's bureaucratic barriers. The strategies used by the democratic government to enact legislation for ISAPRE were both similar and different from those of their predecessors. They were similar in that policy initiatives to advance to the privatization of the system were formulated outside the bureaucracy and led by a change team comprised of policy makers who were considered outsiders by the sector. Differences included the *modus operandi* of the change team itself, *vis a vis* other interested actors, since it favored consensus-building and concessions, instead of insulation.

The new change team's composition reflected the inter-party groups represented in the governing coalition, and thus its level of ideological cohesiveness was not as strong as the former change team's. This eroded the team members' power to enact reforms—and even their ability to agree on a basic common model of health system. The radically different institutional context within which the new change team operated also hindered its potential to insert itself in the policy process and impose a particular agenda. The democratic government's attempts at ameliorating ISAPRE regulation and furthering the privatization of the health care system were not abruptly brought to a halt, but simply ignored and dropped from the public agenda.

COLOMBIA

The speed and scope with which the health reform in Colombia was envisioned and eventually implemented has caught the attention of the international public health community. Certain of its features, such as the fact that it was led by a team of economists drawn from the more technocratic Planning Ministry, its emphasis on bringing about change through regulation, and its tendency to use market mechanisms to manage health funding and provision made a comparison with the Chilean experience inevitable. However, while it can be argued that reformers resorted to similar strategies, the political economy in Colombia empowered a different set of actors—notably legislators—who were able first to promote radical change, and then to influence its final form. As it will be described in detail, and contrary to what could be concluded at first glance, the initial stages of health reform in Colombia (incorporating the issue into the public agenda, legislating it, and beginning implementation) took a shorter period of time than those in Chile. On the other hand, Colombia's more democratic context left its imprint

by making the reform's content larger in depth and scope, aiming at bringing change to the totality of the system.

The reform has prompted a significant transformation of the health sector, and in spite of many difficulties, has obtained significant achievements. The main gains have been the consolidation of new institutions within the contributory and the subsidized regimes that have contributed to the expansion of affiliation in social security coverage in health from 20% to 53%. Also as a result of the reform efforts, significant new resources have been allocated to the health sector. These achievements have been reflected in improvements in access to health care, greater equity, and efficiency gains within the contributory regime.

In spite of the significant progress made in a short period of time, the reform has encountered serious difficulties in achieving its goals in full and its consolidation faces great difficulties. For example, while there has been an increase in affiliation, this has not always been reflected in better access to health services, particularly for the poor. Also, universal affiliation by the year 2001 with the same basic health care package (POS) for both the contributory and the subsidized regimes, will not be possible. Some of the difficulties it faces are related to its mere complexity, which has not been met by the level of human resources available, nor by the country's institutional capacity. This factor is particularly acute due to the regional variations involving these aspects. Furthermore, as it will be discussed in detail, the political aspects of the policy change involved have played an important role in both promoting some elements of the reform, while halting others.

It can be said that the important achievements of the reform have been done primarily with the new resources and through the new institutions, but what existed before the reform has been very difficult to change. As a result, it is cause for concern that a process of segmentation is taking place. This is exacerbating the differences between the two regimes—contributory and subsidized—but also between different income groups affiliated to the contributory regime. Marked differences between private and public health providers remain as well.

The reform's implementation has achieved many of its objectives in a short period of time. However, the second stage of the process in which the reform finds itself today will be crucial not only in determining the overall affiliation level, but in consolidating it and making it sustainable. What lies ahead depends on the completion of the transition process. This necessarily entails the transformation of the old providers and the reallocation of health resources along the lines envisioned in the reform.

Political Economy Context

The political context in which the Colombian health reform of the early nineties was formulated, legislated, and began to be implemented, needs to be explored around a pivotal event—Colombia's process of major State reform and the enactment of a new Constitution. This major institutional transformation was aimed at redefining the balance of power among branches of government, the relations between central and regional authorities, and the role of political parties. And it was aimed at including those social groups that had been disenfranchised from the formal institutional political competition. The new strength acquired by Congress as a result of these reforms raised its level of negotiation in policy making *vis a vis* the Executive. This new balance of power allowed the Congress to condition certain policy initiatives such as pension reform; and to impose others on the Executive, such as the health reform. However, the Executive continued to be the center of policy decision making and to hold enough power to impose its agenda on Congress.

Colombia is an electoral democracy—in fact one of the oldest in the Region—with party rotation, but policy decision making remains exclusionary and elite-based, with parties playing an important role in elections and patronage, but not in policy making through a strong Congress. In fact, the Executive has significant policy making powers. While formally all policy initiatives need to be sanctioned in Congress, many remain exclusively in the domain of the Executive, who, for this purpose, resorts to executive decrees. This situation, even when modified by the National Constituent Assembly (ANC), has been very important in the ability of the Executive to pursue policy change. The Executive has furthered this ability with the creation, since the late eighties, of pockets of efficiency with various degrees of political support, particularly in the economic agencies such as the Central Bank, the Ministry of Finance, and the National Planning Department. It is in these institutions where small groups of technocrats who had the support of decision makers, have played an important role in the formulation of reforms, particularly in those related to economic issues. Nevertheless, during the early nineties, and as part of a major State reform agenda that included both the economic and social spheres, these teams were constituted and embedded in social sectors such as health and pensions, and to develop proposals for the social security reform.

However, the reform proposals of the Executive faced resistance at various levels. The first problem was the existence of factions within the Executive itself, which was the case for the economic reforms during most of the eighties. The same situation arose as a reaction to economic liberalization pursued at the outset of the Gaviria administration – with major resistance stemming from within the Executive, under the leadership of the then Development minister, Ernesto Samper.

When reform initiatives have to be discussed and approved in Congress, the interaction between the Executive and the legislative body is a complex one, due to the characteristics of the party system in Colombia and the composition of the chambers. Patronage and regional competition for public resources are important incentives in the interaction between these two branches of power. The debate in Congress is further eroded by the low level of party cohesion, which forces the Executive to negotiate with each member of Congress to secure his/her vote for an initiative. This situation also demands an elaborate strategy of party coalition management by the Executive and those policy makers in favor of a particular policy initiative.

Outside Congress, there are other groups that intervene in the process of policy making such as producer associations, unions, think tanks, the media, and particular groups that are affected by policy decisions. While all may have some degree of influence at certain stages of the policy process, they are mostly vulnerable to the State's agenda due to the lack of representation, fragmentation in their interaction with policy makers, and poor institutional mechanisms to affect policy formulation.

In the case of health reform in the early nineties, the particular political economy context within which its policy process developed, was determinant. On the one hand, in 1991, a National Constituent Assembly (ANC) was elected by popular vote with the mandate to reformulate the Constitution for the first time in more than 100 years. This agenda of major institutional reform was reinforced by an equally comprehensive State reform under the leadership of the Executive and with the support of Congress. Policy reform included opening the country's economy to world market competition as well as labor reform among others. After the ANC, decentralization, education, housing, and social security reforms were to follow.

The implementation of the second-generation reforms—those related to the social sphere—was undertaken during the following administration of President Samper. This administration held a different position towards what has been called the modernization strategy. It was also

convinced of the need of a consensus strategy around the policy making process and of delaying the pace of the reforms in order to adequate them to the particular circumstances of the country. Also, the Executive's room for maneuver was constrained due to the political difficulties faced both at the national and international level, as a result of political scandals. This situation gave enormous power to Congress and different groups such as the unions and the economic groups, who were thus not only able to obtain important concessions in salaries and privileges; but were able to affect policy content. It was in this political context that the implementation of the second-generation reforms began, with health reform being no exception.

Policy Process

The Colombian social security reform which included the health reform, was approved in Law 100, 1993. It was an ambitious and complex transformation that was made during a period of State reform. The process of definition and approval of the reform took three years. Former President Gaviria, under whose government the health reform took place, has stated that it is probably the most important social transformation in Colombia during the second half of this century.¹⁶ However, the health reform was not part of his initial policy agenda, which focused on the social security reform. Instead, it was the concession the Executive had to make to Congress in order to have the pension reform approved. However, once the Executive took up the banner of health reform, it gave it its full political support and assigned its leadership to Juan Luis Londoño, the minister of Health, and a small and highly trained team working with him.

Law 100 reflects an international trend on social security reform, but the context, including the formal and informal political institutions and the main actors involved, made it particular to Colombia and its political circumstances in the early nineties. The Law was the result of a debate where many "veto points" or "key policy nodes" were important: the National Constitutional Assembly (January—June 1991); the Social Security Commission established by the new Constitution to define the basic points of a social security project (July—December 1991); the reform formulation (1992); the debate in Congress with its different stages: commissions, plenary sessions, and conciliatory process (1993); the drafting of the reform's regulatory body (January—August 1994); the transition decrees (1995); and the implementation process.

Due to the existence of many veto points and the conspicuous discussion that the health reform generated around its goals and means, its final content was the combination of different, even antagonistic, positions. However, most of this process of consensus-building took place before the reform reached the Congress arena, and required the prior conciliation or disarticulation of positions within the Executive itself. Most of the issues in discussion gravitated around the tension between the ideas of solidarity and efficiency that different groups would like to see predominate in the new social security system. The final result was the inclusion of both of them as the main principles sustaining the reform. This debate was constant from the drafting of the new Constitution until the reform's implementation stage.

The other tension present during the whole reform process was settling on the roles of the public and the private sectors. The reform of the health services redefined the relations between the State, the market, and society. This was reflected in the combination of public and private systems that was finally formulated and is being implemented.

During this process, a small group of policy makers, which will be called change team, was established in the Ministry of Health under the leadership of the minister. During the reform's formulation, this team had to interact with other actors such as the members of the National

¹⁶ Hommes et al., 1994.

Constitutional Assembly and the Social Security Commission; the teams working at the National Planning Department, the ISS and the Ministry of Health; unions; and think tanks. Nevertheless, when the proposal was presented to the Congress, the Ministry of Health took the lead and this continued until the implementation phase. During the implementation stage, actors that did not have much influence during the previous stages because the process was insulated from them, assumed a central role. This was the case of health workers, doctors, public health institutions and territorial authorities.

Other important actors during the whole process were representatives from territorial health authorities, unions, congressmen, medical associations, health experts, private research institutes, health workers, Cooperative Organizations, pre-paid medicine, producer and business associations, pharmaceutical companies, and politicians. But the users of the system, the consumers, were not represented either in the case of the contributory or the subsidized system.

Finally, it is important to point out that at the heart of the process remained the change team. A small group of policy makers that, under the Minister of Health's direction and with the support of the president, was able to make important contributions to the decision making process involving the health reform.

Change team and other political strategies

The creation and empowerment of a change team in charge of the reform was one of the government's strategies to pursue health reform in Colombia. This change team was able to achieve results because of the particular strategies it used, but also because its work was part of a larger State reform agenda. Another determinant factor was the team's close relation to the economic change team. While the configuration and empowerment of the health change team was a successful strategy during the formulation stage of the reform process, its usefulness during the legislation stage, and particularly, its effects on the implementation stage have produced mixed results. Thus, because the reform's implementation is still ongoing, which precludes drawing any of firm conclusions, the overall effectiveness of the use of such a strategy remains an open question.

The team's legitimacy came from its academic training and its previous work in government. It was a small group of policy makers, most of them technically oriented, highly trained and with an international background. They saw themselves as apolitical. With few exceptions, none had in mind pursuing a career within government; rather, they were attracted by the possibility of inducing tangible policy change. The team's joint expertise was not only in health or economics, but also in communications, law, and public administration. They worked in isolation from other groups within and outside the sector, and the team was not part of the formal structure of the MOH.

The team's ideological stand was in favor of modernization; changing the role of the State in the social sector; promoting the role of the private sector; increasing efficiency, and using mechanisms other than those historically used in the delivery of social services, such as targeting and demand subsidies. In the team's view, the social sector was relevant as an investment in the country's human capital, and in that sense, as a necessary condition for economic development.

The team did not have a base of political support, nor did it have any particular links with specific groups within or outside the State. Instead, its power stemmed from the support of senior policy makers in core areas of government such as the Presidency, the Finance Ministry, and the Planning Department (vertical networks). It also counted on a network that team members had been building within government during their professional careers with peers in other government agencies (horizontal networks).

This fact gave change team members independence from interest groups, but also highlighted their vulnerability, since the team's permanence in power and its capacity to act, depended exclusively on the support of its vertical networks. In addition to those vertical and horizontal networks, the team worked in establishing State-society networks with particular groups that could support its reform agenda.

The team's composition, networks, and strategies changed according to the particular stage in the reform process. During the stages of formulation and legislation, it had contact with many different groups involved in the reform. However, during the development of regulation it insulated itself from interest group influence. Isolation was partly the result of time constraints, but also it was a deliberate strategy aimed at retaining control over the reform. While this strategy allowed the team to develop an important number of decrees and to establish the basis for the development of the new actors under the new system in a very short period of time, it became an important source of conflict at the moment of implementation.

The team tried to institutionalize policy change through different strategies. The legal strategy, which was very important, was realized in the approval of the Law 100 and its regulatory package. Other strategies included changing key personnel as well as the structure of the MOH; establishing networks with cooperative personnel already working at the Ministry; trying to convince the group that was going to replace them in power of the benefits of the reform; and placing some of the team's members within the new group. These strategies were complemented with the approval of significant loans from the World Bank and the IDB; and with the formation of an international network of renowned international experts that favored the reform. The sustainability and long-term benefits of these strategies will have to be assessed in the light of the reform's implementation, which is still in process.

The health change team made two crucial decisions during the reform that have had mixed results during the implementation process. First, it decided to formulate a law with general principles that could then be further developed with more precision by the Executive during the formulation of the regulatory body. This strategy facilitated the Law's approval and, at the same time, gave enormous room for maneuver to the health change team during the expediting of decrees. Nevertheless, this very same space created by the very general terms of the Law has been used against its underlying principles once the new administration took power and the change team was no longer in control. Secondly, it decided to give priority to the development of the new actors that were to operate under the new system, instead of concentrating on the direct transformation of the old existing ones, which presented great political obstacles. In doing so, the change team thought that the new actors—as well as the new allocation of resources—would stimulate the transformation of the old ones. However, these expected results have taken longer to materialize, and, at present, the health system is composed of an array of new actors in combination with old ones still operating under very similar lines to those prior to the reform.

MEXICO

As was the case in Colombia, the Zedillo administration in Mexico first turned its policy focus to the reform of the social security as part of its economic policy, using pension reform as a means to generate internal savings in the long run. It also sought to avoid the imminent bankruptcy of the social security system. This second element called for a financial restructuring of social security that encompassed its health component. It was only then, and timidly, that the reform of the social security's provision of health services was included on the policy agenda, although it had been formally announced in the government's health sector reform program.

While in Colombia the health reform initiative was promoted and conditioned by Congress in order to pass the pension reform the Executive wanted, in Mexico the health reform initiative stemmed from a faction of social security, which was also involved in the pensions reform. This latter group did not find sufficient support in the economic team and/or with the President. Rather than a coherent long-term health reform process, what is found in Mexico is a series of positive attempts at reform accompanied by reactive strategies that avoid confrontation with major interest groups who favor the *status quo*. As a result, the reform of the health component of the Mexican social security has been delayed until recently. In the last year of the Zedillo administration it has been gathering enough clout to confront resistance to change.

What makes this case relevant for comparative analysis, along with Chile and Colombia, is the fact that in all aspects of the social security reform (and the reform of the health component is no exception), similar strategies for its formulation, legislation, and implementation were used. Notably, attempts were made to create change teams—whose members were outsiders to the sector and drawn from the technocratic economic team in government—and empower them as a means to bring about policy change.

The IMSS reform consisted mainly in the restructuring of all its insurance branches. A pension funds system was created independent of other IMSS accounts and managed by the private sector. The Institute had to further its reform in order to make other branches that previously counted on cross-subsidies from pension funds self-sufficient and thus prevent future deficits. These changes principally affected the health component of social security. The financial restructuring, along with a significant increase in the government's outlay, restored IMSS actuarial equilibrium. Simultaneously, new insurance branches were created in order to offer prepaid voluntary health insurance schemes accessible to informal sector workers and the self-employed. However, there are still serious income and procedural barriers; which, along with a low level of diffusion, have precluded this mechanism from becoming a major means for coverage expansion to the currently uninsured. Efforts at reforming the Institute's health care provision have included decentralization and financial deconcentration to the local level, and attempts are being made at establishing the basis for the separation of the financing and provision functions. However, most of these new mechanisms are currently in the pilot phase. The participation of the private sector and the outsourcing of services have not made any significant progress, and major changes in these areas are not envisioned in the near future.

Political economy context

A distinctive characteristic of the political system in Mexico is the concentration and centralization of power in the Executive; specifically in the President. A series of formal rules support this role, and a group of informal ones strengthen it. The Constitution grants the President formal attributes *vis a vis* the Legislative power, such as the possibility to veto congressional resolutions and the prerogative to send law initiatives to Congress.

These formal attributes are further buttressed by a series of informal rules that convert the Executive into the single most important source of legislative initiatives. Among these informal rules is the fact that until recently, the President was also simultaneously the leader of the majority party in Congress and as such, had the last word on the political careers of politicians that moved through the revolving door of Congress, the Executive, and elected positions in state and local government. These informal mechanisms, in place for more than half a century, have transferred policy decision making and negotiation to arenas outside public scrutiny, and into closed decision making spaces in the official party, and above all, within the Executive itself.

However, the Presidency's informal powers have been weakened as a result of the democratic opening. Since 1997, when the PRI lost its majority in the Lower House, the President has had to negotiate with opposition parties to have his initiatives approved in Congress. Also, given the more competitive political environment, the Executive has had to step up negotiations with its own party members, since political competition has changed the legislators' incentives, and has made it costlier to back unpopular policy initiatives.

A second relevant characteristic of the Mexican political system is the fact that while the old corporatist arrangement has been seriously undermined as a consequence of structural adjustment during the last decade and a half, it is still an effective mechanism in some areas of State influence. This is particularly the case in the provision of public services with strong links to the political rationale of the official political party: the Institutional Revolutionary Party (PRI). Such is the case of social security and the provision of health services, among others, where the corporatist apparatus still mediates the relations between the State and the different social sectors. In these exchanges, corporatist arrangements between the State and society rest on a group of implicit agreements that govern the access to policy making and the distribution of public goods and services. In exchange for organized support, the incorporated sectors receive from the State privileged access to public goods and services.

The corporatist arrangement between the State and society has rested on the inclusion of different social sectors. Among them, three stand out for their economic weight and their capacity for political mobilization: the business community, the labor movement, and the bureaucracy.¹⁷ The business community is not part of the formal structure of the official party, nor does it mobilize collectively in support of the system. However, it has represented both a source of support for the State, and exercised an effective veto for policies that affect its interests. Due to its basic role in the productive processes and its control over financial resources, the business elite has been able to establish direct channels of access to high-level public officials. This has allowed businessmen to have direct influence over policy making.

The organized labor movement has functioned since its incorporation to the official party in the mid-thirties, as the most important organized base of political support for the system. Official unions have been the intermediaries in the relation between the State and labor. The State has established a similar arrangement of exclusive access to public goods and services in exchange for political support with the lower echelons of the State bureaucracy. The intermediaries in the relation between the State and the public servants have also been their unions. However, high and mid-level officials are not unionized and resort to their own support networks, or *camarillas*, to sponsor their political careers.

The debt crisis in the eighties brought the consolidation in the power of the technocracy, a group of policy makers, mostly trained in liberal economics, who were outsiders to the political class). They had build their professional careers as highly qualified technicians in the areas of government that concentrated on economic and public financial management. Their empowerment, as well as the impact of the economic crisis, were determinant in reshaping the economic model and the structure of relations between State and society that were to took form

¹⁷ Organized peasants played an important role during the inception of the corporatist arrangement, but their influence has greatly diminished and reached a formal end with the reform of Article 27 of the Constitution on land tenure during the Salinas administration.

during the late eighties and early nineties. The magnitude of the economic crisis led decision makers to question the economic model in force since the fifties. The technocratic group took advantage of this window of opportunity and their hold on power, to put in motion a new economic model, and to re-establish the grounds for State-society relations under new rules.

The group of technocrats that gained strength within government in the early eighties, was a cohesive team composed of technically skilled individuals whose political careers had developed almost entirely in the financial and economic government agencies. Most of them lacked electoral or party experience. The increase of the technocratic group's influence corresponded to a decrease in power of traditional PRI politicians and union leaders.¹⁸

The technocracy's power peaked during the Salinas administration. The Salinas administration cabinet was even more homogeneous and technical than that of De la Madrid, his predecessor. It was a close and cohesive elite, with roots in the Ministries of Finance and Planning, that extended to other government agencies and monopolized policy making. It accomplished a significant transformation of the economy in the form of market liberalization, deregulation, privatization and the signing of the NAFTA agreement, among others.

However, similar transformations in the political sphere were not to follow, since ironically, the technocracy had to resort to the old actors and political party machine, which it had previously sought to undermine, to consolidate policy change in the areas it considered crucial. This was coupled with other factors including the fact that the economic reforms were slow to show results in people's incomes, there was a political crisis caused by the assassination of PRI's presidential candidate, and a financial crisis was unleashed during the early days of the Zedillo administration. All of these seriously undermined the space for maneuver of the technocratic team that took over from Salinas' close circle.

The Zedillo administration had to improvise a contingency plan and to pass unpopular legislation in order to increase taxes and balance public finances. With the country still slowly recovering from the financial crisis, and the Mexican economy vulnerable to financial shocks due to its lack of internal savings, the Zedillo administration turned to pension reform. This was a mechanism to raise internal savings in the long run – and in the short to medium term, it was a measure to avoid the bankruptcy of the social security system. The political cost of promoting these two reforms (fiscal reform and pension reform) was so high that the government was left with very little political capital. Therefore, President Zedillo opted to reduce his reform agenda and focus on stabilizing the country politically and economically. This explains in part why during five years of government, the Zedillo administration has been reactive rather than proactive regarding the implementation of policy change.

The economic crises and the policies of structural adjustment of the eighties and nineties put enormous pressure on the political system as it had been operating for the last sixty years, and seriously undermined its *modus operandi*. The reduction of public resources and the fact that they had become less fungible, limited the State's capacity to provide public goods and services in an exclusive manner in exchange for organized political support as it had been under the corporatist arrangement. But more importantly, it prevented the political elite from incorporating the growing number of newly mobilized social groups that were not part of the old corporatist pact.

Of particular relevance for the health reform process is the fact that in spite of its ideological opposition to the corporatist arrangement and the limited availability of public resources to maintain it, the technocracy in power has been careful not to tamper with the corporatist

¹⁸ It also meant the displacement of Keynesian economists from high-level positions.

interests in those areas of government that were not considered crucial for the development of the economic agenda. This has been the case of the provider unions that organized the bureaucracy and the health manpower of the social security system, which have played an important role in securing political support for the government and its policies, as well as helping maintain the country's overall political stability.

Even so, the ties between the State and the official unions have eroded and this has favored the strengthening of independent unionism. It was not only the official labor unions that were incapable of protecting the interests of their membership, but new, independent unions, outside governmental control and willing to exercise collective action, have also struggled. As a result, the State's control over groups whose interests were going to be affected by policy reform has dwindled. Simultaneously, the union leadership's control over its own membership has also diminished. While this may not have resulted in a more open and participatory policy debate around reform initiatives, it has certainly made negotiation more complex and unpredictable.

Policy Process

One of the public sector areas in which the corporatist arrangement still pervades, is the health system in its current configuration. Social security services, including access to health care, were, and still are, a central part in the exclusive benefits that organized labor received in exchange for its political support. While it could be argued that social security coverage is granted by law to those with formal employment, just as in the majority of the countries in the Region, the political use of social security benefits is more evident in the *ad hoc* incorporation of particular groups that were not formally employed, or that are politically relevant for the State. This practice started since the IMSS' early days, and has continued up to the present.

This means that the health system's institutional configuration still reflects the old corporatist arrangement, insofar as the provision of health services is perceived as an exchange between State and society along the lines of criteria other than citizenship. In spite of the dismantling of important segments of this corporatist arrangement and the recent democratic opening, the capacity of many middle and low-income groups to obtain more and better public health services still depends on their position within the social strata and above all, their capacity for political mobilization.

The mediator, the IMSS apparatus, has become an interest group in and of itself and a central actor in any reform initiative that relates to health. With its total number of employees reaching more than 350,000, the IMSS bureaucracy and its health personnel comprise the single largest union in the country (and in Latin America)—the SNTSS. It is ready to mobilize its membership at any level of the health services, and in any part of the country in favor of its interests, and holds a collective contract with one of the highest benefits package in the sector. But most importantly, through the last half-century, it has played a major role in politics at party level as well as the federal, state, and local level. The SNTSS retains the right to nominate a number of positions in Congress, as part of the unwritten rules of the political system which gives it a presence and a voice in this arena. Its capacity for mass mobilization at national level in a sensitive area of the public provision of social services, makes the IMSS apparatus and its union, a key ally in electoral politics, and a formidable enemy when its interests are at stake.

The health and social services are focused primarily on the urban industrial workers that are members of the official confederations and other strategic groups such as oil workers, the army, the navy, and the bureaucracy (each with its own health services and social benefits package), a

few peasant groups, and others. Politically non-mobilized groups working in the informal economy, particularly those in the rural sector, have access to public health services provided by the Ministry of Health and poverty alleviation programs. In remote areas according to official figures, still approximately 4 million people with no access to public health services at all.

As part of its political agenda, the Salinas administration attempted to reconfigure the State's coalition of support by incorporating those groups that had been excluded both from political participation and access to public services in the old corporatist arrangement. But, in spite of the creation of massive poverty alleviation and development programs that bypassed the traditional bureaucracy and the clientelistic networks, the new political base did not consolidate at a level that would replace the old arrangement and make it politically expendable.

As a result, the technocracy in power still perceived the need to maintain some of the bastions of the old corporatist arrangement, or at least not to confront them simultaneously, in order to have enough political capital to secure the consolidation of its economic reform agenda. This explains President Salinas' decision not to attempt any reform of the Social Security Institute (IMSS), in spite of the fact that studies being made by technocratic teams in his administration were showing the imminent need for its transformation.

At the outset of his administration, and while the country was in the middle of a very serious financial crisis, President Zedillo decided to go ahead with pension reform. While it is true that Zedillo concentrated his policy agenda on solving the short-term financial and macroeconomic crisis, he viewed pensions very much as a part of this effort. Because of its impact on macroeconomic conditions, specifically on the promotion of internal savings, the reform of the pensions system became a priority in the new government's agenda and its political cost was seen as worth paying.

Thus, President Zedillo supported the implementation of a project that had been developed since the early nineties by officials in the financial and economic agencies of government in the previous administration. The reform consisted in substituting the pay-as-you-go pension system for a scheme of fully-funded individual retirement accounts. Also, as part of the government's promotion of sound fiscal policies, the Finance Ministry decided to promote the financial reorganization of all the insurance funds of the social security system. Its objective was to guarantee the agency's financial equilibrium in the short to medium run and avoid its imminent bankruptcy.

If presented in isolation, these two components in the pensions reform would have forced, as a consequence, the deep transformation of the provision of health services, since the latter operate with great inefficiencies that used to be cross-subsidized by the other insurance funds of social security. Instead, as part of the financial restructuring of the social security system, the Federal Government injected a significant amount of fresh resources and backed it with a legal amendment that augments the Government's share in the tripartite contribution to IMSS. This reduced the pressure for short-term changes. Thus, it can be argued that the reform of the health component of social security was not pursued because it was not perceived as urgent and was seen as politically contentious.

Still, as it will be discussed below, members of the *ad hoc* technocratic teams in charge of pensions reform and particularly the IMSS Directive, did present some aspects of the health reform throughout the pension reform process, but their initiatives were systematically postponed. It is only now, when the Zedillo administration is reaching its final year, that the social security health component reform is gaining momentum, and some of its elements related to the transformation of health service provision are starting to be piloted.

Despite the reduced attention that was given to the reform of the health component of social security by the teams in charge of the pension reform, the government did not abandon it entirely. Many actors within and outside the State discussed the different policy options at hand. While a rich debate developed among these interested actors, their influence in reform formulation was tangential and decision making was kept in a closed arena within the Executive, particularly among the *ad hoc* task groups organized by the core ministries.

In accordance with the technocrats' ideological and programmatic principles, the solutions set forth for the restructuring of the pension system, as well as for the financial reorganization of the insurance funds, reflected the neoliberal premises that efficiency and quality are generated by competition and market—or quasi-market—mechanisms. The need or the potential to introduce the same principles in the provision of health care by legislating an opt-out option for employers that would allow them to contract health services for their employees in the private sector was discussed. However, it was not felt that it was urgent to work in that direction, particularly given the possible political consequences of confronting the social security bureaucracy and its union. As a result, the elements of the law amendment that had to do with the provision of health services, were dropped off the agenda before it reached its formal presentation in Congress.

During the process of formulation, decision making took place behind close doors within the Executive, and the technocratic teams in charge had the power to limit the access and participation of other interested actors, including the IMSS Directive and the IMSS union. But when the proposal was finally to be presented for its ratification in Congress, the players involved changed. The technocratic team resorted to the political maneuvering capacity of the IMSS Directive for the needed consensus-building, and the union was then consulted. Also, the union raised its potential to influence the proposal once it reached Congress through the legislators that represented its interests, and others that for political positioning would join in the resistance effort.

The proposal presented by the *ad hoc* task groups working within the Executive for the pensions reform, which still contained the opt-out proposal for health services, was highly technical, and lacked the political dimension needed to make it feasible to approve it in Congress. It was then that the project's responsibility was put back in the hands of the IMSS director, who was in charge of the consensus-building among interest groups necessary to pass the new legislation. Thus, it was his capacity for political maneuver in Congress, with the business community, the union, and others, that gave the technical team in the Executive the ability to negotiate its reform. Interestingly, through the process of consensus-building and permanent negotiation with the technocratic team, the IMSS director and his team were able to incorporate the political criteria into the proposal, modifying some of its elements in order to make it politically feasible. Notably, it was in these series of decisions that the opt-out option in health services was once more dropped, since it was considered that it could jeopardize the probabilities of the pensions reform's approval.

Once the new Social Security Law was approved in Congress—and in the process divested of any element concerning the reform of the health provision component of social security, the reform process gravitated back to the IMSS arena. With this, the relevant actors and their relative level of influence changed once more. While the pension reform was soon implemented, since its nature had more to do with regulation and the creation of new actors outside the IMSS, the speed and scope of whatever little was going to be done for health, necessarily decreased. This was due to the fact that while some groups within the IMSS directive supported it, they could not count on the backing of senior policy makers in key agencies when facing the resistance of the IMSS bureaucracy and its union.

The group within IMSS that promoted the reform of the health component lacked support from the core government agencies, such as the Finance and Interior Ministries among others. This forced them to sit at the negotiation table with the other groups within IMSS, notably the SNTSS, in order to implement their policy change initiatives. Moreover, because the health reform was not a priority in the Executive's agenda, and a potential labor conflict within the Institute is a serious concern, the IMSS Directive's support for the reform initiative was less than full hearted.

Even after the approval of the New Social Security Law that created the new pensions system, the initiative to regulate the opt-out option remained in the Executive's agenda. Only this time, the *ad hoc* task groups were approaching it from the perspective of the drafting of a new law that would fill in the regulation vacuum in the emergent private health insurance market. Since 1996, an inter-agency group composed of officials from the Presidency, the Finance Ministry, the Health Ministry, and the IMSS started to work on a project to simultaneously regulate quota reimbursement in IMSS and the Health Management Organizations (HMOs) emerging market. In the end, however, once more the political considerations of confronting the IMSS apparatus outweighed the benefits these policy makers saw in pursuing the legislation of the opt-out option, and thus dropped it and carried on exclusively with the HMO regulation.¹⁹

In conclusion, the analysis of the social security reform process identifies three major veto points. The main veto point is located within the Executive, during formulation, when negotiations among government agencies occur. All actors outside the Executive, including the SNTSS, were excluded from this arena and precluded from participating in the decision making process. The veto point located in the Executive was crucial to the health reform, since it was there that it was decided that it should not remain in the reform agenda.

The second veto point is located within the Lower House during the process of approval of the Law. In this case, PRI representatives with direct and indirect links to the SNTSS, vetoed quota reimbursement as a condition for approving the pension system reform and the financial reorganization of insurance funds. The IMSS union opposed the modification of the article that regulates quota reimbursement because they perceived it as a dangerous precedent to the privatization of the Institute.

Finally, the third veto point is located within the IMSS during the implementation period. In this arena, the SNTSS constitutes the principal veto group. The strength of the union is enough to block the change team's reform proposals, which, with no firm support from stronger factions in government, has to negotiate any undertaking regarding policy change implementation. This has affected the speed and scope of the reform process and makes the implementation of an integral health reform very difficult.

Change team and other political strategies

Economic reform in Mexico was promoted during the eighties and nineties, by a small group of technocrats whose careers were based at the financial and economic agencies of government. This team had ideological and programmatic cohesiveness. Its members had a high level of technical training and shared a commitment to the principles of economic liberalism and State reform.

¹⁹ The new law has been approved in the lower chamber and is to be discussed for approval in the upper chamber.

However, given that the informal rules to designate the presidential candidate for the incoming administration made each member a potential nominee, this common ground in ideology and policy content was not always reflected in the team's cohesiveness. At least two factions—or *camarillas*—within the economic change team competed for political power. Thus, these factions struggled for the control and development of the strategic projects that were assigned to them by the President or his close aids. Since its first stages, the social security reform process reflected these dynamics, with both groups of technocrats competing for its control during the Salinas administration.

During the early nineties, a group of these technocrats from the Ministry of Finance and the Central Bank developed a project to privatize the retirement pensions system. The implementation of the Retirement Savings System (SAR), however, did not manage to fully privatize pensions. Therefore, the same team, led by the Finance Minister, continued to work on a project that would bring about the comprehensive privatization of the pension scheme.

Because of its composition, as well as its ideological premises and its programmatic strategies, this team may be characterized as a change team. More precisely, a pensions change team, since its mission and basic objectives were all defined around this issue. However, this group was forced to abandon the project in mid-1993 following a take over by a rival *camarilla* led by the Presidency's Office. It could be argued that this would allow greater control in policy content and a certain degree of insulation from the internal politics around the upcoming presidential candidate selection.

From mid-1993 through 1994, this technocratic faction or “alternative” economic team worked to develop a proposal for the reform of the pension system to be implemented in the following administration. This economic team's strategy to pursue the pension reform followed the same pattern that had been used during the first-generation reforms. A small team was put together with highly skilled economists and actuarial experts, who by training and career experience were outsiders to IMSS, and were placed in formal positions within it. Its leadership was assigned to a junior member of the economic change team who also took a formal position within IMSS. The idea was that this group would thus become a social security change team and, from within IMSS and with the support of the Finance minister, would pursue the pension reform—as well as the financial restructuring of the IMSS—during the administration that was to start. But, the economic crisis unleashed in December, 1994, before the new administration completed its first month in office, not only forced a major revision of the new government's reform agenda in all sectors, but brought about the resignation of the newly-appointed Finance minister. As a result, the change team at IMSS and its leader were left without its vertical network, in other words, the direct support from the core ministries. This narrowed considerably its power, and its scope of action, and it could no longer operate as a change team.

In a parallel process also aimed at influencing the social security reform, both in its pensions and its health component, the IMSS Directive created a think tank—the Strategic Development Center for Social Security (CEDESS)—in mid 1993. The creation of CEDESS can be seen as an attempt by the IMSS Directive to create a change team similar in nature and *modus operandi* to those used by the economic change team. The Institute's directive perceived this as an effective strategy to bring about policy change within a setting of resistance. It also saw it as a good strategy to reach out to the economic team and to establish with it closer ties of cooperation that indeed did occur, but not to the degree it expected.

The task assigned to the CEDESS team was to develop an integral social security reform proposal along the lines and terminology being used by the economic team. The CEDESS group was also instructed to go beyond the economic team's proposal and include the reform of IMSS

health services in an attempt to make it a more “in house” project. Even so, from the outset, the reform of the health component was not given the same level of priority as the pension system reform or the financial reorganization of the Institute’s insurance funds.

The IMSS directive was not successful in transforming CEDESS from a think tank into a change team. The group within CEDESS lacked a series of traits that are indispensable in a change team; but most significantly, it lacked vertical networks of support with links to the core ministries. The economic change team did not recognize the group in CEDESS as an extension of its own, or as a change team with authority to decide and negotiate the reform project and policy strategies

In the meantime, in the Executive, an inter-agency group was designated by the economic cabinet to adjust and negotiate the pension reform project within the Executive. As mentioned above, the 1994-95 economic crisis led the incoming Zedillo administration to incorporate the pension reform as part of its policy agenda. Thus, the economic group empowered this technical team to develop the final reform proposal. Although the reform of the IMSS health component was briefly considered by this group, it was precisely this technical team that decided to postpone it in order to ensure the political feasibility of the new pensions scheme, and thus secure its approval in Congress.

This inter-agency group did possess many of the characteristics of a change team. Although formally it also served as an arena for the representation of the core agencies, this was not its main role. The representation function was subordinated to the concrete goal of formulating and adjusting the reform agenda. Thus, the team worked more as a task force than a space for negotiation. The reason it could not really be considered a change team is the fact that this group was only assigned responsibility for the reform’s formulation; it was not expected to lead the reform process or to participate directly in its legislation and eventual implementation. Nor would it be located, as a team, in IMSS, the agency being transformed.

After the approval of the New Social Security Law at the end of 1995, the reform of the health component continued in two parallel arenas. On one hand, within IMSS, the technical group that had been put in place at the end of 1993—but was abruptly left without a vertical network—kept on working on the financial reorganization of the Institute. On the other hand, another inter-agency task group at the Executive level was created, charged with the task of discussing and developing the quota reimbursement scheme for IMSS, as well as the regulatory scheme for the emerging HMO market. As was true of the earlier group, this latter group was provisional, only responsible for developing a specific aspect of policy change, and was not located within IMSS for its implementation. Therefore, it cannot be considered a change team, in spite of the fact that it did have a high degree of technical expertise, had ideological and policy content cohesiveness, and was insulated from interest group pressure.

This inter-agency task group approached the reform as a regulation problem. This meant setting up the rules for, and creating new health providers similar to HMOs. It thus avoided the reform of the existing public provider institutions. Given that the group intended to “induce” the sector’s reform via regulation, and not via the institutional change of the old providers, it did not face the need to seek consensus among the sector’s bureaucracy and provider groups. However, the regulation of the opt-out clause, or quota reimbursement, would directly affect the interests of the IMSS apparatus, since it has long contended that this would be a first step in a process to dismantle it. Thus, it was this group that briefly brought back the possibility of introducing the opt-out regulation, but soon abandoned it as being too politically contentious and with no clear policy benefits in the short run.

The analysis of the groups involved in the social security reform in Mexico during the Zedillo administration, leads one to conclude that there were several attempts at creating a change team as a strategy to bring about the social security reform, at least in its pension and health components. However, the political context and the series of events that occurred, including the resignation of the finance minister at the outset of the Zedillo administration, precluded the economic change team from creating, empowering, and locating a team with this profile within IMSS. The other factor equally affecting the possibility of pursuing such a strategy, was the unwillingness of the economic change team to strike a firm alliance with the political operators at the IMSS Directive.

Once the change team strategy was put aside, the government resorted to a series of inter-agency task groups that were put in charge of analyzing and drafting proposals for particular aspects of pensions reform, and later on, of health reform. These groups shared quite similar characteristics with change teams, in that they were highly technical, very cohesive, and worked in isolation from interest groups and other bureaucratic factions. However, they were very different from a change team in that they were only put in charge of reform formulation, and were not expected to lead the reform process, or to participate in its implementation. Finally, they were organized as task forces, individuals put together for a particular assignment to which they dedicated part of their time — which was not necessarily their main priority—and then dissolved into the different agencies from which the members came once this task was over.

The technocratic characteristics of the last three administrations in Mexico, along with the presidential control over the Legislature and Judiciary, made it possible for the Executive to create this type of inter-agency group and empower them to promote a reform agenda beyond the control of the provider groups and bureaucratic segments that would be affected by it. The configuration of these inter-agency groups, and the fact that they resorted to the political operators within the IMSS, proved successful in passing the aspect of the reform that was of interest to the Zedillo government; i.e., pension reform. They also made significant advances in legislating a body of regulation for the emerging HMO market, which is currently under discussion in the Upper House.

The participation of interest groups and governmental agencies was restricted and entirely controlled by the Presidency and the core ministries, who, regardless of the policy issue, determined both the degree of participation of the different agencies involved, and thus the composition of the group that was assigned the task of reform formulation. Also, due to the Executive's concentration of power, and the secondary role played by other actors, these inter-agency groups found ample space for maneuver, limited only by the interest of their vertical networks in a given issue.

However, the impossibility or unwillingness to create a change team that could operate within IMSS with the backing of the economic team in the core agencies, reduced the reform to the new legislation on pension reform. From the perspective of the Zedillo administration, its main goal was achieved. But from the perspective of health reform, an opportunity was once again lost, and it is only at the end of the present administration, that timid steps are being taken in this direction.

Finally, the technocratic team that was indeed put in place within the IMSS with the backing of the minister of finance and which had a short life as a change team, did not cease to exist. It continued to pursue the financial restructuring of the social security system, if at a slower pace and with less impact. Most importantly, its lack of autonomy and power, forced it to resort to a consensus-building strategy and to negotiate all of its intended policy changes with the union and the bureaucracy. This considerably limited its scope of action.

IV. MAIN FINDINGS

The analysis of the three cases—Chile, Colombia, and Mexico—demonstrates that there is a dominant model for health reform initiatives in the LAC Region, with a considerable degree of technical agreement about what needs to be done, although discussion continues on the ideal instruments for its implementation. An enhanced role for the market in activities previously restricted to the domain of the State, as well as features of the Chilean model, are reflected in one way or another in the other cases. Reform proposals stemming from the technocratic teams that have been put in charge of reform formulation are strikingly similar in their approach to the roles the market and the State are to take—particularly given that the experience in health provision with this approach has yielded mixed results. This model or vision for the sector is comprehensive in theory, although in practice it has failed to be fully developed in all three cases.

In the policy debate, and indeed in the political struggle around health reform, this pro-market model is counterbalanced by a State-centered approach, which also presents a very clear and comprehensive model or vision for the sector. The latter model also evinces a considerable command of the technical aspects, and agreement among its supporters.

What has dictated the scope of change in the health reform initiatives analyzed in this study, has been the political struggle between the coalitions behind these two broad models. These coalitions are made up of actors within and outside the State and their position is not only interest based, but also runs along clear ideological lines with respect to the roles of the State and the market.

In all three cases, the visible heads of both coalitions are found within the State arena, occupying positions in different State agencies. The pro-market group with its more conservative approach tends to be in economic and financial areas, while the pro-State group with its more progressive view, tends to be found in areas related to the provision of social services, such as health and social security. The main source of power of the first group was the support it received from policy makers at the highest level of the government hierarchy. In response to this, the second group drew on their capacity for collective action and their control over the actual provision of the services. The most visible actors in the second group were the unions, the bureaucracy, and—when in a democratic context—the traditional parties linked to them. However, both factions resorted to the support of actors outside the State, creating State-society networks and mobilizing them in order to increase their bargaining power within government. These State-society networks are made up of, not only unions and provider groups as it has been mentioned, but also of business groups, insurance companies, and international actors among others, who are then used as leverage in the political struggle and the policy debate within government.

In all three cases, the health issue did not appear in the public agenda as a stand-alone subject. Instead, it was generally paired with pension reform in a single policy reform package, or at least its fate was tied to the latter. The fact that in most cases health reform has been discussed and presented along with pensions as a single policy package has in some instances enhanced its political feasibility; while in others, this has caused health reform to be halted and forced off the policy agenda as a potential political liability for pension reform.

In the case of Chile, health reform appears on the policy agenda as a reflection of pension reform, in that the technocratic team wanted to prove that the model used in pensions could be used in the public provision of social services such as health. The Colombian case is a misleading exception, since health reform was dropped by the Executive for the sake of pensions at first, and

only later forced back into the agenda by Congress. Faced with this situation, the Executive then took up the banner of health reform and gave it full political support. In Mexico, health reform appears as part of the pension reform package, but it is there as an element to be negotiated (and readily dropped) in exchange for political support for the pension reform initiative.

No matter how it is finally incorporated into the policy agenda by the technocratic teams, the renewed impetus given to health reform stems from concerns with the public sector's fiscal discipline, and not as a response to pressures from different actors about the need to improve service provision. While in some cases the change team members directly involved may be genuinely concerned with improving equity and the quality of services, the top-level political backing behind the health reforms coming from the economic team is based on an interest in fiscal constraint. In fact, in cases like Colombia and Chile, when the progressive aspects of the reforms such as the expansion of coverage became too costly, the political backing was quickly frozen if not reversed.

It would seem then, that if health reform initiatives are linked to broader urgent financial and economic issues, they are less likely to be comprehensive. Rather they will probably only develop those components directly related to these broader issues. Chile's stated objectives run along the lines of the need to concentrate public resources on low-income groups, and have those individuals with purchasing power buy their own health insurance services in the private sector. The potential expansion of the new health insurance schemes to those with no purchasing power lacked political support and thus failed to be implemented. Mexico's case is the most dramatic, since the only aspect of health reform currently developed is the financial restructuring of the social security services, while health services provision remains untouched. Perhaps the case that was able to move forward most remarkably on the expansion of health provision and the placement of mechanisms that favored equity is Colombia. But this was not without serious resistance from the economic team when it came to the allocation of fresh public resources to this end. The only reason why this initiative was not derailed was the personal intervention of the President giving his support to the reform and to the Minister of Health.

Finally, it is clear that in all three cases the support of the economic team and/or that of the President is a necessary condition for the health reform to have any political feasibility at all. In other words, while the health issue is limited to the MOH, the political and economic consequences of a health reform are of such magnitude that the determining factors—and determinant actors—are beyond the MOH proper. They lie in the core ministries in control of the economy.

In the case of Chile, the backing of the economic team was crucial in critical points of the reform process. When this team was in disarray, the health change team was not able to obtain the needed support to pursue the second phase contemplated in their reform; that is, the expansion of privately managed health insurance for the entire population. In the case of Colombia, the health reform suffered a serious threat when it lost the support of the economic team—a situation that was only solved with the direct intervention of the President in its favor. Finally, in the case of Mexico, there was a serious health reform initiative that was promoted by the IMSS Directive, but since it did not find support in the economic team, it was aborted at the outset. It is thus important to note that the economic team's endorsement is of such importance, that it does not need to make explicit its resistance, since its lack of stated support is enough to derail a health reform initiative.

CONTEXT

A constant question when analyzing the context in which a health reform process is to take place, is the type of political regime in the country being studied. While it remains an important aspect, this study has found that it is less determinant than may be thought. The evidence of these three cases cannot support the general assumption that launching reforms in democracies is a longer and more complex process than in dictatorships. That in Chile, the health change team's struggle took seven years is a case in point. Also, remarkably, the internal politics that took place during those years around health reform in Chile are strikingly similar to what was found in the other two processes, which took place in formal democracies.

The study's findings support recent literature on the level of influence of dictatorships versus democracies on the State's capacity to reform, which suggests that a democracy with a large mandate may be stronger than an eroded dictatorship. It could be argued that the Colombian government counted on a strong mandate to undertake profound changes in the country, and that this served the health reform initiative. By contrast, the government in Mexico, which has historically counted on single party authoritarian mechanisms, was incapable of diminishing the political costs of pursuing health reform, and therefore shied away from it.

An element weighing more significantly in the State's autonomy for bringing about policy change is the institutional configuration of all three countries. This has enabled the Executive, in all cases, to be the most significant veto point in the reform process, regardless of the regime type. This veto point is followed in importance by another one located within the bureaucracy involved in the implementation stage. But even at this stage, it could be argued that the reform's "strength" *vis a vis* the pro-*status quo* groups is highly determined by how it fared in its formulation and legislation stages. The political struggle and factional infighting within the government during the reform's formulation prior to legislation, has proven determinant in both the political feasibility of health reform and in the definition of its nature. It is here that the coalitions in favor and against health reform played out their battles by resorting to their respective sources of power both within and outside the State.

The first possible explanation that comes to the foreground is that both Mexico and Colombia are electoral democracies, with elite-based decision making processes, resulting in autocratic policy making in spite of the formal workings of Congress in both countries. This may hardly be a surprise in Mexico, given its long history of a single party system with—until recently—a government majority in the Legislature. But Colombia, in spite of elections, a rotation in power, and a recently enacted new constitution aimed at empowering the Congress and enabling a more inclusive interest representation, did not present a true balance of powers between the Executive and Congress either.

In the three cases, the strength of the Executive *vis a vis* the other branches of power—notably, Congress—turned it into the single most important arena. It was here that actors with enough power to have influence on the process not only vented their differences, but negotiated their positions with respect to the policy agenda. The balance of power among government factions that was finally reached in the Executive, was then reflected in the Legislature through the formal and informal channels the Executive counted on for imposing its policy agenda. Being aware of this, actors in and outside the State, tried to gain access and voice in the discussions that took place behind closed doors in the Executive. It is only when this approach failed, that other means of gaining access were sought, such as approaching representatives in Congress and eventually, resorting to collective action, such as strikes and marches.

In the case of Chile, the fact that the health reform occurred during a military regime, made it impossible to count on institutional arenas other than the Executive, since both Congress and the Judiciary were overrun. However, the general assumption about Chile during the military regime that the Executive was a monolithic actor functioning along strict military lines that imposed policy change to society, turned out to be unfounded in this area. This study has found that while there is no doubt that interest groups against the regime were severely repressed, dismantled, and denied any participation in public debate, it cannot be said that policy decision making ran along command and control lines within the government, leaving no room for dissent. The study found very dynamic and crisp factional infighting within the military regime with different groups aligned around two opposing visions of the role of the State, in spite of the fact that all factions supported the military regime.

In the case of health reform, and counter to the image of expediency around Chile's experience, it took the economic team in charge of it seven years of bureaucratic in-fighting to master the military's initial resistance and put the health reform on the policy agenda. Also contrary to the common view of this process, during the struggle both government factions resorted to seeking the support of interest groups outside the State (or policy networks), that were sympathetic to the regime, but had competing views on health reform.

At the other extreme lies the case of Colombia. There, it was the Congress, profiting from a particular moment of strength *vis a vis* the Executive due to its emergence from the new Constitution's mandate, that managed to force the issue of health reform into the Executive's policy agenda, and eventually to make its contents more comprehensive and inclusive. Yet, once the Executive assumed the health reform as its own, the Congress lost its control, and its role was reduced to a reactive one. The reform initiative found strong opposition from some legislators that supported the *status quo* and its provider groups, and found formidable allies in legislators that supported the reform for ideological reasons. However, when the decisive moment came and the reform's legislation came up for a vote, the Executive in Colombia was able to work through the elites of both strong parties and have them ensure the needed number of votes. In other words, Colombia is unique in that the Congress finds circumstantial strength to promote a health reform. However, no concrete policy proposal stems from it, and the reform's leadership is eventually assumed and imposed by the Executive.

So even in this case, the main policy discussions and the determinant political struggle took place within the Executive, with the pro-market model gaining preeminence once the group supporting the pro-State model was ousted. In the case of Mexico, the health reform process—starting simultaneously with pension reform, and only gaining momentum once this reform was consolidated—appears to be following the pattern of policy reform processes in authoritarian single party regimes. Although the recent democratic opening led to more plurality in Congress, the Executive remained the strongest single veto point and *de facto* the legislator, still relying on the party under government discipline. Therefore, Mexico is yet another case in which policy proposals of a more orthodox type were only possible because the pro-State policy makers had lost control and power within the Executive, and had given way to the technocracy that was leading structural adjustment.

Another element that makes the Executive the single most important veto point, is that in addition to being the main arena of competition, it also plays a central role as legislator. Chile's case is the most visible, as the military made itself the legislative power. The military put together a legislative mechanism that mirrored that of a legislative body in a democratic context

to ensure the participation and consensus of all the military branches. This enabled the regime's leadership to touch base with the competing positions of the military factions about the policy reforms on the agenda, and structure this competition in a way that would preserve a degree of cohesiveness and ensure a minimum base of support within the regime.

Formal democracies as Mexico and Colombia are cases of strong presidencies and weak legislatures in which legislation is elaborated by the Executive, giving Congress a mere reactive role. The formal and informal institutional arrangements—such as the President's control over his party, political careers being dependent on a person's links to members of the Executive, rather than his/her performance in the polls, the lack of incentives and capacity to professionally analyze policy initiatives much less the capacity to draft policy proposals—all combine to create a vacuum that has been filled by the Executive, who thus both legislates and implements policy.

It can therefore be asserted that in studying the major factors that shape the process of formulating, legislating, and implementing health reform, particular attention has to be paid to the formal and informal institutional features of each country. It could be argued that interest groups outside government might put political pressure on government to modify existing regulation and/or programs, or to bring about significant transformations in a particular sector. But this demand may not reach the government's agenda (particularly in the case of electoral democracies, which otherwise follow an elite-based decision making pattern) if a policy maker or group placed within the high level of government, actually takes the issue and promotes a policy change in response.

Another stage in the reform process in which the regime type could be of crucial relevance is the reform's implementation; and this is in strict relation with the way in which reform formulation and legislation took place. It is argued that if a reform reaches its implementation phase without the backing of a consensus reached during its formulation, it will be stalled. This would mean that in a democratic regime, if consensus is reached, the reform would have a greater chance of being successfully implemented, bearing in mind that this consensus is more difficult to achieve. On the other hand, it is argued that a more authoritarian regime will carry on with a reform in spite of not counting on a consensus, relying on its ability to impose it.

This study has found two aspects that may be of relevance to solve this quandary. First, public health service provision as it has been organized since the creation of national health systems, requires large numbers of providers on the State's payroll, who thus are a relevant portion of the State's bureaucracy. If unionized and politically mobilized, these actors play a relevant role in the political dynamics of their country, mostly as an essential part of the power base that supports the government and helps maintain stability. In this regard, authoritarian regimes are no exception to the rule. The cases in this study, particularly Chile, prove that a military regime is also dependent on a political power base, and that the bureaucracy is a central actor in it. Thus, it can be concluded from these cases that the strength and political will to alienate or oppose this portion of the government's power base does not depend on the regime type, but on its level of political capital when implementation is to take place.

The second aspect is the fact that choosing the moments and points of confrontation with actors against change by limiting their access to the reform process is not a unilateral decision of the change team. In both military regimes and democracies, provider groups whose interests are potentially affected, can choose the moment in the reform process in which they are best able to exert pressure in favor of their interests. The more authoritarian the regime, the less access these groups will have to reform formulation and legislation, but in all cases, implementation will depend on them. Thus, they can choose to flex their political muscle once the reform process has reached their realm again.

In this second scenario, the regime type will determine the degree of influence in the first stages of reform, but in none of the cases studied, was it the case that the regime type had a significant influence on the State's capacity to diminish the veto power of the bureaucracy. In the cases of Chile and Colombia, where reforms were legislated albeit—in an *ad hoc* mechanism in the case of Chile's military regime, visible changes have only occurred in the creation of new provider actors (ISAPRE in Chile, EPS in Colombia). In the case of Mexico, recent legislation has enabled the creation of similar provider actors, although the drafting of secondary law or regulation, is still very much at work. Old public providers with large bureaucracies continue to operate very much on the lines prior to the reforms.

POLICY PROCESS

As set out in the analytical framework, it is possible to identify in a reform process the following critical stages or phases: definition of the problem, formulation of policy reform, legislation, implementation, institutional change, and consolidation. While reform processes seldom occur in a straight line and in a clear time horizon, all these stages can be identified, if in some cases with less clarity than in others. The most relevant points regarding reform formulation have been analyzed in the previous section on the political context in which a reform takes place, in order to stress the importance of the Executive as the main veto point.

Following the institutional rules of a democratic regime, once the moment of formulation is over and the Executive is ready with a reform proposal, the policy process moves to the legislative arena. In the case of a democratic context, the reform now enters into the realm of party politics. However, as it has been presented, Mexico and Colombia are formal democracies, but their institutional mechanisms do not offer inclusive policy decision making. In other words, the Executive counts on an overwhelming number of mechanisms, both formal and informal, through which it can exert significant control over decisions made by legislators.

In the case of Colombia, Congress did have a significant influence in the process, and ultimately added a series of alterations to the original reform proposal. Because pension reform was the government's priority, negotiation with Congress was mainly left in the hands of the Minister of Labor, with the health team appearing as apolitical/technical policy makers. Health reformers did, however, give personal attention to the interested legislators from all parties and positions, both within and outside the commissions reviewing the initiative. This group of legislators comprised advocates for the two competing models previously described, and the reform was modified in several key aspects due to their participation. As a result, one of the characteristics of Colombia's reform, currently being implemented, is that it tries to respond to the goals and values of the two opposing positions.

Why then say that the Executive is the main veto point?

The role of the legislative branch of government should not be underestimated in transforming the nature of the reform, but the study has found in both Mexico and Colombia that the Presidential power was overwhelming and that the head of the Executive used this power to ensure the votes for those initiatives with the highest priority in its agenda. In other words, health reform did not pass in Mexico because it did not count on the support of the Executive, rather than the fact that members of Congress resisted it. It could be argued that actors opposing the reform made the political cost of passing it too high for the Executive, but yet again, the center of gravity of this resistance was not located within the Congress. In the case of Colombia, the President made use of its leadership to ensure enough votes from both the party in power and the opposition.

An analysis of the complex relationship between the government's political capital and its party's discipline to vote in favor of reform initiatives is another line for further research. For instance, politicians in their political career, face a revolving door between their career as representatives and as policy makers within the Executive apparatus. The fact that their career will develop in both arenas determines the incentives for party discipline in voting on the Executive's initiatives. However, having the majority in Congress may not guarantee an easy legislation process. On the contrary, the study has found that the opposition played an important role in Colombia in order to ensure the legislative approval of the government's policy agenda. In the case of Mexico, even with a legislative majority, the government got involved in one of the most arduous episodes of negotiation with its own party members, since a legislator's incentives to vote in favor of a government's proposal that affected powerful interest groups, particularly unions, are not clear cut. It is expected that as the democratic opening evolves, this dilemma will become more acute.

When the reform reaches its implementation stage, the relevant arena ceases to be Congress and gravitates back to the Executive, since regardless of the market's level of participation in the sector, the State remains the principal provider and manager of health services. Thus, with the change of arena, the actors that are capable of influencing the reform process also change, and, most importantly, their capacity to influence the process varies. A relevant case in point is that of the provider groups. It has been stressed that reformers do not have unlimited capacity to determine when other actors are to have access to the reform process, even if they resort to a series of strategies aimed at insulating the process. As a parallel process, the actors that fear that their interests may be negatively affected by the reform, particularly provider groups, choose the moment in the reform's process in which they have most strength.

This helps explain why the groups resisting change may only timidly try to influence the legislation process, since they have the option of threatening collective action once the reform reaches its implementation stage. Colombia's experience certainly points in that direction. Given the depth and scope of the policy changes being considered, it is remarkable that there were very few marches and strikes of unionized providers and the bureaucracy at the time. Instead, actors resisting change "regrouped" after the new legislation had passed and simply did not alter their *modus operandi* at the pace they were expected to. These actor's strategic choice of the place and moment for exerting pressure against change explains in great measure the lack of congruence between what is approved in the new health laws, and what is really being implemented in practice.

This finding may run counter to the political economy literature that stresses that the political negotiation that is avoided during reform formulation, presumably through the isolation strategies of the reform team, will resurface during implementation. In other words, they argue that when consensus building is avoided, the need for it will reappear in later stages of the reform process. These cases suggest the need for a complementary explanation, in which actors opposing the reform may not simply "resurface" during implementation when denied access to previous stages, but instead, they may have actually chosen to do so as a more effective strategy. In other words, actors against the reform are not necessarily reacting to the insulation strategies of those in charge of reform formulation, but instead are following their own active strategy in which they chose their moment of maximum strength to exert resistance to policy change.

Having said that, it must be stressed that in all three cases change teams, or technocratic groups in the case of Mexico, do explicitly strive to isolate themselves and the reform process from the influence of other actors by exerting control over access to decision making spaces. They continue to do so until the institutional rules of the game force them to "open" the process. Such is the case when the reform needs to be ratified in Congress and during implementation. A

case in point is the experience in Colombia. The change team worked on the reform proposal in an isolated manner until it opened the process in order to lobby for its approval in Congress. The bill that was crafted by the team and eventually approved, lacks precision in most of the issues, in part, to accommodate the competing positions of the different actors involved. But it is also, in part, because this opened up room for maneuver during the crafting of the regulatory provisions, which could be developed in isolation without interest group pressure. In doing so, the team gave itself the opportunity to “bring back” the reform to the team’s original vision during the drafting of the regulations. The Chilean team also used its mandate to craft the regulations and the legal amendment itself away from the scrutiny of other actors wanting to participate. In fact, the stepping stone of the creation of ISAPRES was introduced by the health change team leader in a miscellaneous bill presented by the Labor Ministry to the Legislative Commissions.

Another common feature of the political economy of policy change is to treat the middle and lower bureaucratic levels of the provider institutions as a separate, independent actor from unions and provider groups. In the case of Mexico, where State-labor relations are structured through official unions, the study has found that it is not relevant to treat them as separate actors. While the leadership of unions and associations may well have a different agenda than that of their membership and indeed the experience of the Medical Association in Chile during the health reform is a poignant example, middle and lower level bureaucracies seldom are mobilized or articulate their demands as a body apart from their unions. This is why provider’s unions and associations are usually major obstacles to reform and central actors during its implementation phase.

Thus, further research needs to be carried out on the nature of provider unions in the social sector, including their characteristic political strategies and their influence on the political feasibility of health reform. For instance, it is not clear that a union’s or a professional association’s lack of internal discipline and cohesiveness enhances the political feasibility of the reform by strengthening the reformers’ potential to impose change. The experience in Colombia shows that the lack of recognition of the provider groups’ leadership has made agreements and consensus about the reform volatile and unpredictable, thus diminishing the chances for successful implementation. Thus, provider group fragmentation does diminish their negotiation capacity, but also undermines the potential for a firm support base when consensus is reached.

This does not mean that change teams pursuing health reform may not and have not resorted to a “divide and conquer” strategy by selectively distributing benefits and, most importantly, costs among provider groups and other key actors that may see their interests affected by the reform. Such was the case of Chile, where the military was exempted from joining the new health insurance scheme, and its resistance successfully deactivated. The array of provider unions in Colombia also gave rise to such strategies, as was the case of the powerful teachers union, that was neutralized by giving it reassurances that its membership’s affiliation under the new scheme would not be enforced.

Finally, although both the coalition defending the health system’s *status quo*, and that in favor of reform claim to have as their ultimate goal benefits for the system’s users, the study has found that users seldom have any voice in the reform process as such. Users rarely have the organizational capacity for collective action and thus the potential to exert pressure on decision makers, nor do they have a clear understanding of their rights to health care. The information asymmetry in the health field makes it even more difficult to determine the issues around which users could organize for collective action, and very little progress has been made in any of the three countries to establish effective institutional channels for user participation.

Interestingly enough, Chile's literacy level and its long democratic culture prior to the coup d'état, has been referred to as a possible explanation for the level of sustained demand for primary health care across the country during the dictatorship. However, the authoritarian regime systematically impeded social participation in State and economic reforms, including health, with the sole exception of those groups favorable to the Regime.

The more democratic institutions of Colombia and Mexico, failed nonetheless to go beyond electoral representation, and to incorporate the population at large, particularly the poor, into the politics of policy in specific areas such as health reform. The sole exceptions were those groups of beneficiaries organized around other issues that could extend their capacity for collective action to defend their interests in the area of health as well. The population at large has largely been excluded from political participation and low-income groups are not generally clear about their basic rights as citizens. Therefore, the potential to mobilize the average citizen in favor of a health reform that may result in more and better access to health for all is very low.

In the case of Mexico, for example, consumers of public health provision systems belonging to low income groups with low literacy tend to show a very low degree of dissatisfaction with the quality and access to health services. This is true in spite of objective data about the lack of quality and availability of services. However, it must also be taken into consideration that the constitutional right to access to health care was only established in the mid 1980s in Mexico and the early 1990s in Colombia. It is also the case that provider groups, when protecting their interests, present themselves as the guardians of the beneficiaries' rights to health care, albeit this is generally only in political discourse—a strategy that has found strong resonance in the population at large as has experienced in Colombia. In the case of Mexico, the IMSS union has tried to strike an alliance with other unions using this discourse, but has failed thus far due to political rivalries in the labor movement. However, its formation will depend on the final content of the health reform initiative and how it affects both provider groups and users who already count on the unionization of collective action. A coalition of this size and nature would present a formidable political challenge for policy change.

In considering the situation of those with limited access to health care at present, one important fact is that, with the exception of the chronically ill, the need for access to health care is felt individually and sporadically as opposed to collectively and systematically. This is quite different than the case of education, the other major social service provided by the State. This further diminishes this group's potential to exert pressure in favor or against a health reform initiative. The potential for collective action is further minimized by the absence of common interests beyond the construction of a hospital or health facility close to town, the presence of health personnel, etc. Also lacking is a single definition of the policy problem and its solution, due to the complexity of the issue. Thus, the politicization of the health issue and the mobilization of these segments of the population is reduced to short-term, immediate demands related to specific and visible episodes, such as the closure of a hospital, lack of health personnel or medical supplies, and the threat of an epidemic among others.

CHANGE TEAMS AND THEIR POLITICAL STRATEGIES

What are the characteristics used to define a change team? Much has been said about the cohesiveness of the team and the degree of insulation from interest groups in their work. Both are critical factors. But the study has found that a change team can only be distinguished from a tight group of technical policy makers when its members are given the responsibility and are empowered to go beyond reform formulation. A change team is assigned the leadership of the

reform process beyond the reform's technical formulation, and to do so, it is required to move from the purely technocratic field into the political arena. It does so by choosing and following the political strategies it needs to ensure the legislation of the reform and to put in place the elements that are expected to bring about change—such as resource reallocation and new regulations. In other words, a change team is assigned the responsibilities to formulate policy, get legislation passed, and initiate implementation of a reform initiative. In order to do so, it needs to go beyond the technical aspect of the reform and become involved in the political dynamic of the process.

To be able to operate effectively in this political arena, the change team needs what this study has labeled “vertical” and “horizontal” networks. Vertical networks are the constant support of key policy makers in power; i.e., the President, the Minister of Finance, and the Minister of Planning. Perhaps surprisingly, the support of the Minister of Health has proven not to be indispensable. Resistance within the health sector is also bypassed or countered via the change team's horizontal networks with sympathetic colleagues in other agencies or veto points within the State. Horizontal networks are those that, although not able to give strong political backing, because they generally are at the same hierarchical level as the change team, do allow the latter to present their case at critical junctures to other agencies involved. Sometimes this even enables them to overcome major cleavages between the heads of different sectors. Horizontal networks also facilitate access to critical information at the right time and in the right place, and may also support the initiative with studies whose handling within the ministry in reform would be delicate.

In the case of Mexico, once the change team failed to be sustained because of the loss of its main source of power and support (vertical network) from the Ministry of Finance, the government resorted to a series of inter-agency groups that were created to formulate particular aspects of the social security reform, particularly pension reform. However effective they might have been, these groups cannot be considered change teams as such, since their members did not abandon their activities in their respective home ministries, nor were they, as a team, in charge of brokering the reform in Congress or implementing it once it was approved. A question remains about the competing objectives of the members of these groups. On the one hand, there was an element of inter-agency representation, since each came from a different ministry; on the other, they were assigned a particular task (by the Presidency, in this case) and were ordered to work as a cohesive task force, leaving representation aside. Another exception that confirms the rule is the failed attempt of the IMSS Directive at creating a change team. In this case, the team of highly trained policy makers were put exclusively in charge of formulating a reform proposal, they formed a fairly cohesive group, and they worked in isolation within the IMSS itself. However, the IMSS Directive was unable to endow the team with the vertical networks of support stemming from the core ministries – like Finance, and the President's Office. The latter never quite adopted this group as part of their strategy to reform social security. As a result, the group worked as a technical group that fed technical studies and policy proposals to the inter-agency group that had been created under the auspices of the President's Office, but did little else.

In all the cases presented in this study, the backing of the Finance Ministry was a necessary condition, a *sine qua non*, regardless of the political backing of the minister of Health himself or of any other ministries involved. A government's political capital, as well as the financial resources it can use to promote reforms, is scarce and unstable. In such an environment, an argument based on fiscal limitations stemming from the Finance minister against a health reform initiative, tends to prevail against any other argument made in favor of health policy change. In the best of cases, the Finance minister's opposition may not derail the entire reform, but will probably severely limit its scope. Colombia's health reform initiative faced one of its greatest challenges when the

Finance Ministry raised these issues, and it was only solved through the direct intervention of the President. On the other hand, the backing of the Ministry of Finance along with other core ministries has proven sufficient to pass a reform, even without the backing of the MOH's leadership. Such was the case of Chile.

But vertical networks may not be sufficient if the change team is not capable of building horizontal networks across sectors and veto points that will facilitate the reform's process without the constant need for the explicit backing of the top leadership. Similarly, if the change team is unable to build horizontal networks within the ministry itself via consensus building and/or substituting personnel deeply enough in the bureaucracy, it may find its reform efforts halted or reversed as soon as it leaves office, in spite of having enjoyed top-level political backing while working at the MOH. In sum, the change team will need vertical networks to win its large determinant battles, but will also need a diverse and expansive horizontal network to fight the small everyday battles. Both levels need to be resolved if the reform is to be put in place. Further research is needed to relate the political context to the preeminence of vertical networks over horizontal networks. For instance, could it be argued that vertical networks are more important in authoritarian regimes, but tend to lose significance (if never totally) to horizontal networks as the political system is more democratic, and thus presents a larger and more complex number of veto points?

In Chile, the change team operating at the MOH counted on the direct support of the Ministry of Finance and the Planning Department (ODEPLAN). These two ministries systematically used a strategy of "colonization" in which they sent members of their teams to work formally and permanently in all other ministries where they interested in pursuing in-depth reforms. Change team members never ceased to have a close line of support—and command—that was in many occasions stronger than their relation to the formal structure of the ministries in which they were appointed. Informal meetings were held weekly in which this group of technocrats would meet to discuss policy and the public agenda. In these forums, the health change team was able to present its case, lobby resources, command/obtain technical studies, and consolidate support for their reform initiative while circumventing the resistance or caviling of senior policy makers in their own ministry. The group operated as a horizontal party within government, in that it had its own identity and reform agenda, its networks of support, and a clear ideological stand that ran counter to the majority of the members of the military government in which they were embedded. Finally, they also sought to establish policy networks and thus get support from groups outside the State that, although sympathetic to the regime, were striving for an open economy with a significant role for the market.

Thus, the picture that emerged from this study is rather more complex than the conventional argument that reforms in Chile were simply imposed by the military apparatus in power. While it cannot be denied that little could be achieved without the approval of the military Junta and thus, both the economic change team and the health team were able to achieve what they did because of the Junta's ultimate support, the technocratic policy makers who were organized in the form of change teams fought a serious bureaucratic battle with the military establishment who viewed their proposals with deep suspicion and resentment.

Interestingly enough, when the military regime ended, the first democratically elected government resorted to the same political strategy to bring about policy change in the health sector. That is, they resorted to the creation and empowerment of a change team to pursue health reform. However, this strategy proved entirely unsuccessful. This change team was created with the support and resources of the multilateral agencies, but its nature and the logic behind the recruitment of its members was entirely different from the previous change teams. Obeying to the circumstances and pressures of the new political context, the change team's cohesiveness

and common vision, was sacrificed for the sake of a meticulous representation of all the political parties that composed the governing coalition. As a result, the common ground in which to work on a policy proposal and settle technical differences was absent. Also, for the same reasons, the newly created change team lacked clear vertical networks stemming from the core ministries, which would have ensured a minimum level of political support *vis a vis* other interest groups in the sector that opposed change. The change team was not able to exert any authority within the sector it was assigned to reform, and was largely ignored. The group soon reached paralysis and was quietly dismantled after two years of being unable to produce results.

Does this mean that the change team strategy is only feasible within an authoritarian regime? Of the three cases analyzed by this study, Colombia presents the most democratic political context, in that it has party rotation. Also, the period in which it initiated its health reform stands as one moment in Colombian history in which the Congress has reached a peak level of influence, thus bringing into the policy debate a series of voices that had seldom been heard in the past. Yet, it is in this context where the study found the other successful case in the use of a change team as a strategy. Granting the fact that Colombia's formal democracy remains, in spite of its reform, elite-based, it can be asserted that it bears little resemblance with Chile's military regime. Its institutions and its political culture are closer to a democratic regime, than to an authoritarian regime. As a result, the change team that was created and assigned the responsibility of pursuing health reform, was able to profit from the particular strength of the Executive, which was able to insulate it from interest group pressure. But it also had to confront a more active Congress ready to use its veto power. Thus, one finds a change team with all the traits that have been discussed—ideological cohesiveness, high technical skills, work in isolation, and the use of vertical and horizontal networks—making use of them for its political maneuvering in a more democratic context.

The strategies the Colombian health change team resorted to, as well as the results it obtained, would not have been possible without the direct support of the President. As in the other two case studies, provider groups and other interest groups that favored the *status quo*—notably the bureaucracy and the doctors—resisted change. But what makes this case unique is that the health change team in Colombia had to face, if only momentarily, resistance from its key vertical network, the Finance Ministry. At a certain point, the Ministry raised questions about the fiscal sustainability of the reform and its impact on the political feasibility of the pensions reform. This formidable challenge was only solved—and under the circumstances could only have been solved—by the direct support of the President, the only vertical network of higher hierarchical standing.

The characteristics of the team itself and those of its members are also crucial. Their background, knowledge, and previous policy experience, greatly determine the content of their reform proposals, as well as the political strategies they will resort to, and ultimately, their ability to maneuver. For instance, in all three cases, health change team members had had previous experience in first-generation reforms. These reforms were in the economic sphere and had been oriented to changes in regulation. This was notably the case with the leader of the short-lived change team in the Mexico case, who was expressly appointed there because of his experience in deregulation. Thus, they tended to construct both the content of health reforms and their political strategies to pursue it, along the lines and assumptions they had successfully used before. That is, they tended to base the health reform's policy content on changes in rules and regulation and budget reallocation, and eschewed areas in which the cooperation of provider groups was needed. This was true in spite of the fact that this cooperation—be it by consensus or by confrontation—is indispensable for the implementation of second-generation reforms such

as that of health, since the State through its bureaucracy and provider groups remains the single most important health service provider.

Considering the political strategies these change teams followed, the influence of their previous experience creating successful political strategy involving in-depth structural change is also visible. Strategies such as using a highly technical policy content to limit the participation of other actors, the element of surprise, the drafting of laws and regulations away from public scrutiny, and the selective participation of other groups in society with a particular interest in the sector being reformed, were all effectively used during first generation reforms. There seems to have been a general assumption that these strategies could be replicated with the same effect in pursuing second-generation reforms.

In all three cases, the fact that the social sphere presented an entirely different challenge in that the State needed to change its *modus operandi* as the main provider if reform was going to be accomplished does not seem to have been perceived as relevant in the eyes of the health change teams that were analyzed. All three change teams shared the common assumption that whatever changes that were not achieved in the short run by confronting major interests in the sector, would happen in the mid-term as a result of the market forces being put into motion by the reforms. In the two cases that did initiate reform implementation—Chile and Colombia—this has failed to be the case, and instead, has severely limited the scope of change.

Is the use of change teams as a strategy the result of cross-national influence or has there been significant influence from multilateral organisms? There seems to be an indication of this in other country experiences that are beyond the scope of this study. However, little evidence can be found of this in the case studies being analyzed. The case of Chile's economic change team under the Pinochet regime has been the subject of a variety of studies focusing on Chile's technocrats also known as the "Chicago boys." This study was able to confirm that a change team of similar characteristics was used as a strategy in the pursuit of Chile's health reform as well. Although they were familiar with the case, it is not clear that Colombia's health reformers used the same strategy as a direct result of Chile's experience.

The precedents for the creation and use of a change team of similar nature in Colombia, can be traced back to the long process of professionalization of core segments of its bureaucracy, creating pockets of efficiency which started in the sixties and had as its main axis the Planning Department. As a result, the eighties witnessed the emergence of the technocracy as a distinctive group that reached power—a phenomenon that is in fact shared by all three countries. The change team strategy was used first to bring about economic and State reform, and then to produce policy change in the social sphere. This was the case in all three countries, regardless of their very diverse institutional contexts and regimes. Mexico also presents an important process of selective State modernization and profesionalisation that resulted in the rise to power of the technocratic policy makers. This groups shares the ideology and the policy approach of technocratic groups in Chile and Colombia, but it cannot be argued that their use of change teams was a response to these two countries' experiences.

V. FINAL REMARKS: OLD ACTORS VERSUS NEW ACTORS— PUTTING THE PERFORMANCE OF CHANGE TEAMS INTO PERSPECTIVE.

Chile's health reform was legislated in 1981; thus, it is about to complete its second decade. It could be argued that there has been enough time to assess the current configuration of the health care system, and to compare it with what had been envisioned by the change team twenty years ago. Colombia legislated its reform in 1993, and thus it is currently into its seventh year. This short period of time limits the possibility of making an objective assessment of the new health system's consolidation. Mexico's attempt at health reform happened in 1995, when the new social security Law was approved. It is only recently that new attempts are being made at health reform, but there remains no time for significant changes during the present administration. This initial failure should be put into perspective, considering that Chile's reform took seven years to reach legislation and later implementation. Thus, the study's analytical strength is undermined in this aspect by the fact that, with the exception of Chile, not enough time has passed to allow for an evaluation of the performance of all three reform initiatives. However, all three reform initiatives present similar tendencies that are worth analyzing when putting the change teams' performance into perspective.

Are change teams effective in bringing about health reforms? In the case of Chile and Colombia, change teams were successful in formulating reform and passing it through legislation or its equivalent process in Chile's military regime. Their effectiveness in these two stages of a reform process proved to be sufficient in the case of economic reforms, since as has been stated, changing the rules and the incentives with new legislation and resource reallocation, was enough to change the roles and activities of the economic actors, including the State itself. Major elements of economic reform such as deregulation or lowering tariffs, did not require significant changes in the *modus operandi* of large segments of the bureaucracy. If there were any changes at all, a few bureaucratic segments were made redundant and in a few cases were dismissed. But, what makes health reform a second-generation reform by definition, is that, as long as the State remains the main provider, health reform entails the transformation of the *modus operandi* of large segments of government employees—both health providers and bureaucrats—in order to achieve a significant transformation of the health care system.

It can also be argued that health reforms entail another aspect related to changing the rules of the game. On the one hand, it creates new actors through passing new law and regulation and changing resource allocation; and on the other hand it requires the in-depth transformation of the old actors; that is, the government agencies in charge of providing health services for the majority of the population prior to the reform initiative. Thus, a reform would only be complete when it manages to create the new actors and to transform the old ones, as it was envisioned in the reform proposals in Chile and Colombia. Experience in health reforms shows that when old actors fail to be transformed, they can become serious obstacles for the consolidation of the new actors and for the overall advancement of the reform of the system as a whole.

The actors involved in the political dynamics around these two intricately related aspects of a health reform are quite different. So are the political costs and benefits of confronting them. Thus, change teams have had to make decisions about which aspect to develop first, at what speed, and the degree of "dependency" among the two processes. In the cases that did reach their implementation stage (Chile and Colombia), the transformation of old actors was left for a later stage or halted by *pro-status quo* interests. It could also be argued that the change teams postponed the transformation of the old actors as a strategy to ensure the political feasibility of a

major part of their reforms, which was the creation of new actors and the introduction of market forces into the system. As stated above, one of the assumptions behind this strategy was that market forces would induce the change that was being avoided by the State. In other words, in both Chile and Colombia, change teams took this decision based on the assumption that the new actors and the new rules of the game for the sector, were eventually going to force old actors to change without the necessity of direct confrontation.

It is also possible that this decision was not made entirely by the change teams themselves. As explained in the case studies, the decision may have been forced by their vertical networks, who were unable or unwilling to give their political backing to confrontation of old provider groups such as the bureaucracy and the unions. This explanation has its roots in the senior policy makers' perception of the State's limited political capital; i.e., political support and the need to preserve a political base in order to pursue priority policy initiatives, other than health.

In any case, this not only has resulted in incomplete health reform processes, but has created major obstacles for the consolidation of health reforms as a whole. Of particular importance, it has seriously jeopardized the possibility of attaining a single universal health care system with a plurality of providers. Both Chile and Colombia's reform initiatives envisioned the creation (and consolidation) of a single health system covering the entire population with the exception of the very poor. Thus, in Chile, the change team's plan consisted of a first phase in which the ISAPRES were created, followed by a second phase in which the subsidized ISAPRES (*ISAPRES Populares*) were to be launched along with the privatization of public hospitals. As a result, a universal system would have been created with a subsidized component for those groups with no purchasing power, and a regular health insurance market for the majority of the population. Serious attempts were made for this second phase to be implemented, but they generated mixed results, and the change team was unable to gain the political support to go ahead with the completion of its health reform initiative. As a result, today ISAPRES cover approximately 26% of the population, with the rest still resorting to the old, under-funded public providers.

Colombia introduced the "second segment" of the reform from its outset: the creation of the subsidized regime and the ESS as a building step towards a unified health care system with multiple providers and demand subsidies for the very poor. The expansion of coverage of health services through the new mechanisms and actors that have been put in place by the reform is by any standard remarkable. Social security coverage went from 20.6% in 1991 to 53.0% in 1997. But the failure to transform the highly inefficient Social Security Institute (ISS), given its status as the single largest health provider with 62% of total enrollees in the new EPS system, is quite serious. This has the potential of creating a serious financial disequilibrium in the new system and is putting its eventual consolidation in jeopardy.

Thus it may be concluded that while the use of change teams has proven its efficacy in inducing policy change through regulation and resource reallocation, it has failed to bring about the restructuring of public provider institutions. This certainly limits the scope of health sector reforms. In order to achieve the transformation of these old actors, interest groups that are normally excluded from the reform process, notably provider groups, need to be taken into consideration; either via consensus-building or confrontation. So far, given their nature and position, change teams seem to have a serious limitation in this regard, in that they have been unable or unwilling to do either. Further exploration needs to be made about the usefulness of change teams in transforming the existing provider actors, and thus contributing to the political feasibility of more comprehensive health reforms.

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