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The Politics of Healthcare Expansion

Combining compelling field research with sharp analysis, *The Politics of Healthcare Expansion* unravels why efforts to expand equitable healthcare so often fall short – and why some succeed. Through comparative case studies of Chile, Mexico, and Peru, this book reveals how political party commitment, or the lack of it, shapes the design, implementation, and sustainability of healthcare reform. Moving beyond ideology, it demonstrates the crucial role of programmatic party engagement and analyzes the impact of technocrats and external actors when political parties are weak or disengaged. With timely lessons highlighted by the region's COVID-19 experience, this book offers rigorous insights and practical implications for anyone seeking to understand or influence social policy reform in emerging democracies.

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The Politics of Healthcare Expansion

Policy Reform and Political Parties in Latin America

Zoila Ponce de León

University of Pittsburgh

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abbreviations

Acronyms

ACP	Private Clinics Association of Peru (Asociación de Clínicas Particulares del Perú)
APRA	American Popular Revolutionary Alliance – Peruvian Aprista Party (Alianza Popular Revolucionaria Americana – Partido Aprista Peruano)
ASE	State Solidarity Contribution (Aportación Solidaria Estatal)
ASF	Federal Solidarity Contribution (Aportación Solidaria Federal)
AUGE	Universal Access with Explicit Guarantees (Acceso Universal con Garantías Explícitas)
AUS	Universal Health Insurance (Aseguramiento Universal en Salud)
CEO	chief executive officer
CNPSS	National Commission for Social Protection in Health (Comisión Nacional de Protección Social en Salud)

CONFUSAM	National Confederation of Municipal Health Officials (Confederación Nacional de Funcionarios de Salud Municipal)
CPOs	causal process observations
CS	social contribution (Cuota Social)
CTIN	National Implementing Technical Committee (Comité Técnico Implementador Nacional)
EPS	Health Provider Entity (Entidad Prestadora de Salud) – Network of private providers
EsSalud	Peruvian Health Social Insurance (Seguro Social de Salud del Perú)
FMU	Universal Joint Fund (Fondo Mancomunado Universal)
FONASA	National Health Fund (Fondo Nacional de Salud)
Funsalud	Mexican Foundation for Health (Fundación Mexicana para la Salud)
GDF	Government of Mexico City (Gobierno de Ciudad de México)
HSRP	Health Sector Reform Project

IFIs	international financial institutions
IMF	International Monetary Fund
IMSS	Mexican Social Security Institute (Instituto Mexicano del Seguro Social)
Isapres	private insurance institutions (Instituciones de Salud Previsional)
ISSSTE	Institute for Social Security and Services for State Workers (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado)
LyD	Liberty and Development (Libertad y Desarrollo)
MEF	Ministry of Economy and Finance (Ministerio de Economía y Finanzas)
MINSA	Ministry of Health of Peru (Ministerio de Salud)
MINSAL	Ministry of Health of Chile (Ministerio de Salud)
PAHO	Pan American Health Organization
PAN	National Action Party (Partido Acción Nacional), Mexico

PDC	Christian Democratic Party (Partido Demócrata Cristiano), Chile
PPC	Christian Popular Party (Partido Popular Cristiano), Peru
PEAS	Essential Plan for Health Insurance (Plan Esencial de Aseguramiento en Salud)
PELA	Parliamentary Elites in Latin America
PHR*plus*	Partners for Health Reform*plus*
PNP	Peruvian Nationalist Party (Partido Nacionalista Peruano)
PPD	Party for Democracy (Partido por la Democracia), Chile
PR	proportional representation
PRAES	Promoting Alliances and Strategies
PRD	Party of the Democratic Revolution (Partido de la Revolución Democrática), Mexico
PRI	Institutional Revolutionary Party (Partido Revolucionario Institucional), Mexico

PRSD	Social Democrat Radical Party (Partido Radical Socialdemócrata), Chile
PS	Socialist Party of Chile (Partido Socalista de Chile)
PSMMG	Free Medical Services and Medicine Program (Programa de Acceso a Servicios Médicos y Medicamentos Gratuitos)
REPSS	State Regime of Social Protection in Health (Régimen de Protección Social en Salud)
RN	National Renewal (Renovación Nacional), Chile
SEG	Free School Insurance (Seguro Escolar Gratuito)
SERMENA	National Health Service for Employees (Servicio Médico Nacional de Empleados)
SF	Solidarity Fund (Fondo Solidario)
SIS	Comprehensive Health Insurance (Seguro Integral de Salud)
SMD	single-member district
SMI	Maternity and Child Insurance (Seguro Materno Infantil)

SNS	National Health Service (Servicio Nacional de Salud)
SP	Seguro Popular (Popular Insurance)
SUNASA	National Health Superintendency (Superintendencia Nacional de Salud), 2009–2013
SUS	Unified Health System (Sistema Único de Saúde)
SUSALUD	National Health Superintendency (Superintendencia Nacional de Salud) in Peru
TAHRP	Technical Assistance and Hospital Rehabilitation
UDI	Independent Democratic Union (Unión Demócrata Independiente), Chile
UN	National Unity (Unidad Nacional), Peru
UPP	Union for Peru (Unión por el Perú)
USAID	United States Agency for International Development
VAT	value-added tax
WHO	World Health Organization

1
Social Policy Reform in New Democracies

Over the past few decades, Latin American countries have strived to expand access to healthcare and reform a system that discriminates against citizens based on their socioeconomic status. Millions of people are lost to preventable deaths, and, moreover, people in a low-income group face an increased risk of dying from treatable diseases. Access to healthcare services can prevent early death and plays a crucial role in promoting economic growth and improving people's well-being. Therefore, healthcare reforms that expand access are highly significant. However, these reforms vary across countries, with some more comprehensive and sustainable than others and involving different levels of planning. What accounts for these differences in the quality of healthcare reforms? How and why do key social policy reforms succeed or fail in Latin America's new democracies?

The importance of these questions has been highlighted by the experiences of Latin American countries during the COVID-19 pandemic. With over 2,700 deaths per million people, Peru had the highest mortality rate from COVID-19 worldwide as of December 2020. This was unexpected because it was one of the few countries in the region that responded early to the pandemic (Taj and Kurmanaev 2020). Despite early efforts to contain the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the Peruvian government was unable to control its spread as it struggled to meet the healthcare needs of its population. A swift surge in cases led to the collapse of

an already overstretched public healthcare system (Ponce de León 2021a). The collapse of the Peruvian healthcare system and the resulting high mortality rates revealed the failure of previous reforms to sufficiently achieve effective healthcare access. Understanding why countries like Peru, which initiate reforms, often fail to deliver is crucial, as unsuccessful reforms can cost lives. Conversely, the Chilean government was able to rely on a stronger healthcare system in its COVID-19 response. Thanks to reforms started in 2004, access to healthcare significantly improved. The COVID-19 death toll in Chile was 841 deaths per million people by December 2020, one of the lowest in the region.

Reforming a healthcare system is challenging. This book highlights that the most important indicators of a reform's success are sustainable funding and infrastructure development, both of which a healthcare reform legislation must include. I argue that the policymaking role of political parties is essential in shaping both the quality of reform legislation and its implementation. Political parties differ greatly in several aspects, including organizational structure and strength, ideological coherence, internal power distribution, and the level of personalism. I focus on programmatic commitment: how well parties maintain coherent programmatic values and how those values relate to the specific policies. Emphasizing the roles of political parties and other key actors, such as technocrats and the private sector, helps explain the varying success of healthcare reform efforts in Latin America.

Many scholars have doubted the feasibility of extensive, high-quality policy reforms in Latin America's new democracies. Explanations range from

limited resource availability to clientelism. Some argue that the weakness of democratic institutions, including fragile political parties, is an important factor (Przeworski et al. 2000; McGuire 2010, 2020; Segura-Ubiergo 2007). Nonetheless, broad social policy reforms have been carried out across Latin America. Some studies suggest that new democracies can implement widespread reforms if they have strong parties and institutionalized party systems (IDB 2005; Scartascini, Stein, and Tommasi 2013). Meanwhile, others have debated whether policymaking should be managed by technocrats and insulated from political pressures (Dargent 2015; Silva 2009; Centeno 1994; Centeno and Silva 1998; Williams 2006; Teichman 1997; Eaton 2003).

The study of social policy reforms in Latin America has mostly focused on cases with established party systems. We know little about social policy reforms in countries like Peru, often called "*democracies without parties*," where political parties are non-programmatic, weak, and unstable (Levitsky and Cameron 2003; Levitsky 2018). Comparing these cases to those with stronger and programmatic parties can reveal how and why this difference influences policy reform. Additionally, as party systems in the region and worldwide become more fragile, it is crucial to examine how reforms are developed, implemented, and sustained under these conditions. How are policies created differently in these contexts, and what are the impacts of these processes on the people these policies aim to serve?

I argue that a programmatic commitment from political parties to the policy in question is essential for the reform to succeed. A party has a

programmatic commitment to a reform when its core values are directly aligned with the policy. In Chile, for example, the core values of equity and social inclusion united all but one of the center-left Concertación coalition's political parties. The link between these core values and the expansion of healthcare led the Concertación to bring the issue of healthcare reform to the legislative agenda, participate in defining policy details, and commit to the sustainable implementation of the reform.

I argue that being programmatic alone is not enough to explain why political parties participate in or influence policymaking. What truly determines their participation and impact is whether a specific policy aligns with the party's core values, thereby creating a programmatic commitment to that policy. For example, if a policy relates to a core issue like a state-run versus a market-led economy or a Catholic versus secular state, the party will likely have a programmatic commitment to it. Conversely, if a policy does not connect to the party's core values, there will be no commitment. In this way, being programmatic does not automatically mean having a commitment to every policy issue. When parties become involved in shaping crucial specifications of the reform regarding implementation and funding during the debate over it, this involvement creates a commitment to implementing the reform, which in turn influences its feasibility and long-term sustainability.

Healthcare reform, however, can also occur in countries where parties' core values do not directly relate to healthcare issues and can even happen in situations where parties lack core values altogether. In such contexts, we must

ask three fundamental questions: (1) Why do these countries undertake reforms in the first place? (2) How does this process occur? (3) How does this process influence the quality of reform? Previous research has demonstrated that electoral competition is highly relevant for answering the first question, as parties might be motivated to pursue reforms to attract votes from lower socioeconomic groups (Ewig 2016; Fairfield and Garay 2017; Pribble 2013; Garay 2016; Altman and Castiglioni 2020), regardless of their core values or ideology. Governments may also pursue reform in response to external pressures and incentives from international institutions (Armada, Muntaner, and Navarro 2001). To address the second question, I suggest that when parties without a programmatic commitment to healthcare reform implement such policies, they are unlikely to be the creators of these policies, nor will they be the ones putting the issue on the political agenda. Instead, technocrats from think tanks or international organizations without partisan ties will lead the policymaking process. The manner in which reform is pursued is as important as the reasons behind it; understanding the *how* helps us grasp how technocratic influence can either improve or undermine the quality of reforms aimed at expanding healthcare access. My research shows that policymaking by technocrats without the support of committed parties can result in poorly designed policies and flawed implementation.

The Politics of Healthcare Expansion shows that reforms can follow different paths. One path involves parties with core values closely tied to the policy issue playing a key role in shaping the reform's details. Another path

occurs when parties disengage from defining the reform's specifics, allowing outside actors to take charge of the policymaking process. These actors outside the government – such as think tanks, international organizations, organized interests, or individual technocrats – then dominate the policymaking process. Both paths can result in reforms that expand official coverage and increase funding for the health sector. The main difference lies in the quality of the reform: how feasible it is to provide access to healthcare and how sustainable its funding remains.

I test my argument by comparing the processes of reform in the 2000s that aimed to expand access to healthcare services in three Latin American democracies: Chile, Mexico, and Peru. In Chile, a left-wing coalition in power, composed of programmatic parties, enacted the country's universal access with explicit guarantees (Acceso Universal con Garantías Explícitas (AUGE)). In contrast, a programmatic right-wing party in power presided over the Mexican Popular Insurance (Seguro Popular). In Peru, non-programmatic parties pursued universal health insurance (Aseguramiento Universal en Salud (AUS)). To analyze the policy process of these reforms, I draw on twelve months of extensive field research in all three countries. I trace the influence of the presence or absence of a programmatic commitment of political parties through over 150 in-depth interviews, archival data, and reform statistics across three different stages of policymaking: agenda-setting, debate, and implementation. This influence is central in explaining why wide-ranging social policy reforms succeed or fail in delivering their promised expansion of benefits in Latin

America. This question is particularly relevant today, as healthcare systems in the region, and worldwide, have been put to the test during the COVID-19 pandemic.

This study finds that although the long-term goals of the healthcare reforms in Chile, Mexico, and Peru were largely similar (expanding access to healthcare services to the population and increasing the number of diseases treated), there are crucial differences. Whereas the increase in funding for the health sector has been stable in Chile, the funding of the reforms in Mexico and Peru has not been consistent or sustainable. Similarly, whereas the budget for the reform in Chile grew constantly, budgets were reduced in Mexico and Peru. Another crucial difference is that in Chile, but not Mexico and Peru, the increase in formal coverage has been accompanied by a parallel expansion of infrastructure and human resources. The impact of stable funding and planning for infrastructure development is evident in the difference in the rate of change in human resources, infrastructure development, and effective access when comparing Chile to Mexico and Peru. Furthermore, while the Chilean reform has endured through different governments, the Peruvian reform has been precarious, and the Mexican Seguro Popular came to an end in 2020.

Unlike previous work, this book examines not only policy formation and adoption but also implementation. Moreover, it extends beyond the literature that highlights the significance of left-wing parties and party system institutionalization to demonstrate that healthcare reforms will succeed only when parties have a programmatic commitment to the reforms.

The Relevance of Healthcare Reform in Post-Neoliberal Latin America

The implementation of neoliberal policies in Latin American countries in the 1980s and early 1990s left the region sharing a common challenge: increasing social inequality in access to healthcare (Ewig 2010; Castiglioni 2005; Brooks 2009; Arza et al. 2022). There were significant disparities between citizens who used the public health sector's services and those who could afford private services, as well as between citizens with formal jobs who had access to a healthcare scheme through salary contributions and those within the informal economy who were usually unprotected (Ponce de León 2023). The inefficient provision of access to healthcare and precarious healthcare infrastructure remain critical areas that require action in Latin America.

Reforms aimed at expanding access to social benefits have promised to alleviate this social inequality. Such reforms have the potential to improve living standards for disadvantaged populations and the country's population overall – after all, access to healthcare can prevent early death and remains a primary factor in promoting development (McGuire 2010) and overall welfare expansion (Sen 1999). Although healthcare access should be a fundamental right of citizens in a democracy, it is not present everywhere. Furthermore, in comparison with other social policies, the expansion of healthcare services can be more redistributive (Huber and Stephens 2012).

The political process behind the formation of reforms seeking to expand access to healthcare can significantly affect the prospects for tackling the

existing disparities. Although many governments in the region put healthcare reform on their agendas, not all of them fully commit to the reform. The absence of political commitment to a reform aimed at expanding access to healthcare can severely hinder its success. Therefore, understanding the circumstances under which actors such as political parties and technocrats help (or hinder) the development of reforms that succeed in expanding access to healthcare can inform policymakers and politicians alike.

Several countries in Latin America, including Argentina, Brazil, Chile, Colombia, Mexico, Venezuela, Uruguay, and Peru, have implemented reforms aimed at expanding access to healthcare (Garay 2016; McGuire 2010; Pribble 2013; Arza et al. 2022; Huber and Ponce de León 2019). As Martínez Franzoni and Sánchez-Ancochea (2016) discuss, policies labeled as "universal" have become popular among both international organizations and national governments. Governments undertaking these reforms call their policies "universal" because they "seek to reach everyone, even if they entail unequal benefits" (p. 6). The quality of these reforms, however, has varied in terms of both the expansion of benefits and sustainability.

In an effort to understand the variation in the quality of policy reforms in Latin America, some scholars have focused on the strength of democratic institutions, including party system institutionalization (IDB 2005; Scartascini, Stein, and Tommasi 2013; Przeworski et al. 2000; Mauro 2017). Some scholars have argued that democratic factors such as electoral competition (Ewig 2016; Fairfield and Garay 2017; Garay 2016; Pribble 2013; Altman and Castiglioni

2019) and pressures from civil society matter (Haggard and Kaufman 2008; Filgueira 2007; McGuire 2010, 2020; Niedzwiecki 2014; Garay 2016; Anria and Niedzwiecki 2016), while others have pointed out the importance of clientelism as a factor hindering universalistic reforms in the region (Shefner 2012). In the context of clientelism and corruption, experts have also discussed the advantages of technocratic policymaking (Dargent 2015; Centeno 1994; Centeno and Silva 1998; Williams 2006; Teichman 1997). The expertise that technocrats bring to the table can be beneficial, particularly when connected to a government's political program (Martínez Franzoni and Sánchez-Ancochea 2016). However, I demonstrate that isolated technocrats from think tanks or international organizations who fail to engage with key political actors in government and the opposition design reforms that lack the necessary political commitment to successfully carry out their implementation and ensure their endurance.

An important set of studies has demonstrated that political parties, particularly strong left-wing parties, are important for quality reforms (Esping-Andersen 1990; Huber and Stephens 2009, 2012; Murillo 2005, 2009; Pribble 2013; Pribble and Huber 2013), while others have noted that the presence of programmatic parties affects policy quality (Stein and Tommasi 2007). Programmatic parties are organized around a coherent set of policy alternatives that make up the party program and appeal to citizens based on such policy programs (Kitschelt et al. 2010), have a vision of how society should be organized, what the most pressing problems in a society are, and a plan to solve

them. In Latin America, we have witnessed the decline of many programmatic political parties and the emergence of weakly- and non-programmatic parties (Kitschelt et al. 2010; Levitsky 2001; Levitsky et al. 2016; Mainwaring 2018; Mainwaring and Zoco 2007). By the early 2000s, Chile and Uruguay were the only remaining countries that had strongly programmatic political parties, Mexico had some programmatic parties, while parties in Bolivia, Colombia, and Peru were weakly programmatic (Kitschelt et al. 2010).

My contribution is to show that it is a party's programmatic commitment to the policy area in question, not the party's strength, that matters most for the quality of reform. Specifically, I go beyond the argument that programmatic parties will always deliver better policy by focusing on the relationship between the core values of a party and the policy area in question.

Explaining the Initiation of Social Policy Reform

In the late 1990s, most Latin American healthcare systems shared two key features: fragmentation and inequality. Healthcare was divided between a public and a private sector, with the first being segmented into a social security system and another system for those outside the formal economy. This meant that different segments of the population had access to different healthcare benefits (Ewig 2010; Pribble 2013). Citizens with formal jobs had access to a healthcare scheme through salary contributions, whereas those within the informal economy (over 50 percent of the Latin American population)[1] were

[1] 53.1 percent in Latin America and the Caribbean in 2016 (ILO 2018).

usually unprotected. Many governments in the region have attempted healthcare reforms with the primary goal of alleviating these disparities, with varying degrees of success.

Several factors have been investigated to explain this variation. One prominent area of study focuses on economic factors, finding that a country's wealth is a significant predictor of policy reform, as it ensures the necessary funds for reforms to be implemented (Segura-Ubiergo 2007). However, countries with the same level of economic development choose different types of social policies, both in high-income (Esping-Andersen 1990; Huber and Stephens 2001) and low-income countries (Filgueira 2007; Huber and Stephens 2009). In Latin America, episodes of social policy expansion have occurred during both periods of economic growth and economic crisis (Garay 2016).

On examining how political factors shape the expansion of social policy, democracy is found to be favorable for the development of policies aiming to expand social benefits (Przeworski et al. 2000; Sen 1999), as well as positive health outcomes (Bollyky et al. 2019). Democracy opens a channel for different groups, particularly those being excluded from the provision of benefits, to make demands of their governments (Haggard and Kaufman 2008; Filgueira 2007; McGuire 2010, 2020). In Latin America, Garay (2016) finds that both electoral competition and social mobilization can trigger the expansion of social benefits, but only social mobilization guarantees a broad scope of coverage. In Mexico, for instance, competition from a left-wing party pushed conservative parties to undertake healthcare and pension reforms.

However, in the absence of social mobilization, the Mexican government enacted restrictive policies.

Other studies have focused on the diffusion of policy models to explain the emergence of reform. They find that policy innovations spread across countries (or local units), as foreign models captivate policymakers, driven by political self-interest and inferential shortcuts (Weyland 2006) or ideological commitments (Sugiyama 2013). Although international institutions started to lose interest in healthcare policy by the late 1990s (Dargent 2015; Ewig 2010), the World Bank, World Health Organization (WHO), and the Pan-American Health Organization (PAHO) were still advocating for an expansion of healthcare to excluded segments of the population, thus raising governments' awareness of the need for change. As Weyland (2006) points out, given that a singular model of healthcare reform is extremely rare, diffusion in this area does not arise in the form of policymakers borrowing models.

An influential body of literature has focused on the role of strong left-wing political parties in understanding the emergence of reforms seeking to expand social benefits (Huber and Stephens 2009, 2012; Pribble and Huber 2013; Anria and Niedzwiecki 2016; Anria and Bogliaccini 2022; Kapiszewski, Levitsky, and Yashar 2021). Pribble's (2013) work on the development of social policy reform in South America demonstrates how the internal organization of left and center-left parties influences the universality of a policy. Depending on the strength of the ties between the elites and the base within the party, a policy may move further toward universalism. Right-wing

parties act as opposition to the policies that Pribble studied, and their ties to business determine the extent to which a bill reflects business interests.

Reforms aimed at expanding access to social benefits have also been implemented under the rule of right-wing parties. A focus on the responsibility of the left for social policy reform risks overlooking the influence of factors beyond ideology on policymaking. A small but significant group of studies over the last few years has drawn attention to reforms enacted when right-wing parties were in power. Electoral competition (Ewig 2016; Murillo 2009) and social mobilization are found to explain the expansion of social policy in the region regardless of party ideology (Fairfield and Garay 2017; Garay 2016).[2] In Mexico, for instance, given the lack of social mobilization, the competition from the left-wing Party of the Democratic Revolution (Partido de la Revolución Democrática, PRD) pushed the right-wing National Action Party (Partido Acción Nacional, PAN) to undertake reform seeking to expand access to healthcare.

An underexplored aspect of the policymaking process is the role of the actors who pushed for reform, placed the issue on the agenda, and shaped the legislation and its implementation. In the case of the Mexican healthcare reform, the process behind *how* Seguro Popular reached the political agenda

[2] Niedzwiecki and Pribble (2017) study recent reforms enacted by the right in Chile and Argentina, showing that they have either maintained the status quo of social policy already in place or allowed policy drift.

and the role of PAN (or lack thereof) in the development of the reform deserve further attention. The lack of programmatic commitment from PAN, as well as the other parties, led to a reform that was poorly designed for implementation and lacked political commitment to its sustainability. In the case of Peru, given the lack of electoral competition and social mobilization, we should not expect the development of healthcare reform at all. The Peruvian AUS, however, shared similar results to the Mexican reform in terms of formal coverage.

Although arguments about the prospect of electoral gains or diffusion may clarify *why* political parties preside over reforms, they fail to explain *how* they do so and the level of engagement they have in shaping policy, which can ultimately determine the quality of the reforms. Explaining the initiation of a policy is important, but so is explaining the quality of legislation and implementation. This quality, I argue, depends on the programmatic commitment of parties.

The Argument: Programmatic Commitment and Policymaking

Although multiple scholars have studied the importance of institutionalized and programmatic parties for democratic consolidation and representation (Aldrich 1995; Levitsky and Cameron 2003; Mainwaring 2018; Mainwaring and Scully 1995), their impact on the policymaking process has been underexplored. Some studies have highlighted the importance of these party features for the quality of public policy (IDB 2005; Scartascini, Stein, and Tommasi 2013; Stein and Tommasi 2007). However, these large-N quantitative studies do not explain

how programmatic parties influence policymaking. *Why do programmatic parties have a positive impact on the quality of reforms? How are reforms adopted in the context of non-programmatic parties? What are the consequences of such reforms?* These questions remain unanswered.

We can distinguish two components in the programmatic nature of political parties: (1) programmatic unity of its leaders and (2) programmatic appeals to voters. When studying parties as policymaking actors, it is the first component that deserves further evaluation.[3] A party *is* programmatic when it has core values that unite its leaders. These core values are what programmatic parties care about the most and, therefore, unite parties organically; they drive the party's program.

I argue that whether a party is programmatic or not fails to explain the participation and impact of parties in the policymaking of healthcare reforms. Instead, we should pay attention to whether a specific policy connects with the parties' core values, producing a *programmatic commitment* to the policy. A party may hold core values on important policy issues such as a state-controlled versus market-driven economy or a Catholic versus non-religious state, but only if these values connect with the policy issue at stake will the party develop a programmatic commitment to the policy. Instead, suppose a party's core values fail to relate to the policy. In that case, the party will not generate a

[3] Regarding the second component, research shows that parties can use different types of linkages to attract different constituencies at the same time (Luna 2014).

commitment to that policy, the definition of its specifications, or its implementation.

In the case of a policy proposal that aims to expand healthcare access, if a party holds equity and social inclusion as core values, it will have a programmatic commitment to shaping the policy in alignment with these values, promoting reforms with a broad scope of coverage. Alternatively, suppose a free market is a core value of the party. In that case, the party will hold a programmatic commitment to shaping the policy in alignment with this core value: promoting minimal state intervention in the healthcare system and the participation of the private sector. Whereas if Catholicism is a core value of the party, since a proposal seeking to expand access to healthcare does not directly relate to this value, the party will not necessarily hold a programmatic commitment to shaping the policy specifications.[4] We must understand the programmatic nature of parties in terms of policy issues rather than as a blanket statement.

[4] In Latin America, Catholic political parties have generally held strong positions on the role of the Catholic Church in politics, acting against secularizing reforms and holding conservative social stances, particularly defending traditional family structures and opposing same-sex marriage and abortion rights (Hawkins, Kitschelt, and Llamazares 2010). Their positions regarding the social provision of services such as healthcare or education have been mixed.

Therefore, we can expect reforms to follow a *programmatic path*, in which parties with core values closely tied to the policy issue play a central role in defining the reform's specifications. But *how do we explain healthcare reform in cases where parties' core values do not directly relate to a policy issue, or in cases where parties lack core values altogether?* In these cases, reforms may follow a *technocratic path*, in which parties disengaged from defining a reform's specifications allow outside actors – such as think tanks, international organizations, organized interests, or individual technocrats – to dominate the policymaking process. Both paths can lead to reforms that expand formal coverage and even increase funding for the health sector in the short term. The key difference lies in the quality of reform, specifically in the feasibility of ensuring access to healthcare and the sustainability of funding.

The programmatic commitment of parties shapes critical specifications of a policy regarding implementation and funding. Moreover, the programmatic participation of political parties in defining specifications fosters a commitment from these same actors to implement the reform, which in turn determines its feasibility and sustainability. When parties lack core values or such values do not align with the policy, legislation may still pass, but technocrats without partisan ties often dominate the process. Given the lack of commitment from the main political actors, the policy will be poorly designed for effective implementation, suffer from unstable funding, and fail to provide sufficient infrastructure.

The ideological position of a party influences, but does not determine, the presence or absence of a programmatic commitment to a specific policy. We expect left-wing parties to be more inclined to pay attention to and direct funding toward the development of the welfare state than right-wing parties (Blais, Blake, and Dion 1996; Castles 1982; Huber and Stephens 2012). In Latin America, we can generally position parties along the left-right ideological spectrum based on their views on the need for state intervention to generate equality and social inclusion (Levitsky and Roberts 2011). Therefore, it is indeed more likely for the left to have a programmatic commitment to expanding social benefits. However, if the left-wing party fails to have social equality and inclusion as a core value uniting its members, as seen in Peru, it will not forge a commitment to the policy.

On the other hand, if the party holds social equality and inclusion as core values, but the policy in question does not relate to such values, it will lack a programmatic commitment to the policy. Thus, the party will fail to produce sustainable funding and the necessary infrastructure to implement it. For instance, in the case of environmental protection policy, the left in Latin America has not been at the forefront of developing high-quality reforms.

The participation of right-wing parties in the policymaking process of social policy also depends on what core values they hold. If the protection of the private sector is at the core of their program, right-wing parties will try to prevent policies that could restrict the expansion of the private sector. However, suppose the party highly values a strong hand against crime or

traditional family structures. In that case, many social policy reforms will not be viewed as a threat to such values. Hence, the party will fail to engage in defining policy specifications and the policymaking process in general.

The policymaking process can be outlined in key stages, including agenda-setting, debate, and implementation (Jones and Baumgartner 2005; Kingdon 2010). The presence or absence of programmatic commitment to a policy influences the policymaking process at each stage. During agenda-setting, it determines whether political parties or actors outside the government place a policy issue on the political agenda and lead the process. If a policy issue relates to the core values of a party, the party will introduce the issue to the agenda. When programmatic commitment alone is insufficient to introduce reform, the pressure generated by social mobilization and popular support can play a relevant role in compelling political parties to prioritize the issue and include it on the agenda (Fairfield and Garay 2017; Garay 2016; Gibson 2019).

If the issue does not relate to the core values of any of the parties, or if they lack core values uniting their members, a connection between the policy issue and the parties is absent. Under these conditions, actors outside the government, such as think tanks, international organizations, organized interests, or individual technocrats from these organizations, will place the

issue on the political agenda.[5] A chief motivating factor for these stakeholders to place reform on the agenda is the presence of alternative reform proposals that they see as undesirable.

During the debate stage, the programmatic commitment of parties determines the specifications of the bill regarding implementation and funding. When a reform proposal is directly related to the core values of a party, the party attempts to shape the proposal in accordance with its program. The participation of political parties in shaping the bill's specifications helps generate a commitment to the reform prior to its implementation. When they do not participate in the process and in deciding critical specifications of the reform, there will be no political commitment to the reform. The presence of programmatic commitment (when parties' core values are connected to the policy issue) is a major incentive for the party proposing the reform to engage critically in shaping policy specifications.

A strong opposition (in terms of the number of legislators) to the reform can constrain the role of parties with a programmatic commitment to social policy. If opposition votes are necessary to pass the legislation, proponents of the reform will have to negotiate different aspects of the bill, giving the opposition leverage to shape the policy in response to their demands (for

[5] Following previous scholarship, I use a widely accepted definition of technocrats (also called experts): individuals with a high level of expertise or specialized training (Dargent 2015; Centeno & Silva 1998).

instance, to require that the policy protect the private healthcare sector). If the opposition agrees to pass the bill after this negotiation, they will participate in defining the specifications as they seek to ensure that the private sector remains protected under the implementation plan. The participation of proponent and opposition parties in shaping policy specifications, although complicated and lengthy when ideological differences are present, induces political commitment to the policy from both sets of players.

When the programmatic commitment of parties is absent, other factors will determine whether members of the party support or oppose it. For instance, they might support a reform following the party leadership's command, concerned about electoral competition (Ewig 2016; Murillo 2009), or for the new resources it entails. In turn, they may oppose the reform because it could harm their ability to enforce patronage. If the reform is only tangentially related to parties' core values or in the context of parties that lack core values, they will not engage in shaping key aspects of the bill, such as funding and infrastructure.[6] Instead, they will leave the process in the hands of individual technocrats. Technocrats without partisan ties will be allowed the freedom to introduce poorly specified bills, which politicians will not care to shape, thus generating poor-quality legislation. Although these bills may be technically effective, they will be politically impractical. This expectation contradicts what

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

some literature on technocrats and policymaking argues: that technocrats, as authors of bills, will produce higher-quality legislation. I contend that technocrats isolated from the political process can overlook the politics of implementation. For instance, they may neglect to pay attention to the future need for political support in financing the reform and, therefore, fail to include firmly anchored financing mechanisms in the legislation.

Technocratic actors may also play an active role in the context of programmatic parties, but they are likely to have partisan ties. Martínez Franzoni and Sánchez-Ancochea (2016) demonstrate that in the case of Costa Rica, the presence of experts affiliated with a programmatic political party in government was highly relevant to the development of successful reform. In contrast, I argue, in the context of non-programmatic parties, technocrats without partisan ties often lack a strong political commitment to the policymaking process, given the short-term nature of their influence. The participation of technocrats does not always lead to poorly specified bills, but in the context of parties that lack a programmatic commitment to the policy and technocrats without partisan ties, there is a widespread lack of political commitment. Table 1.1 illustrates the impact of programmatic commitment on the quality of healthcare legislation, tracing its effect across the three main policymaking stages.[7]

[7] Although an alternative outcome is no reform at all, this book only focuses on approved reforms.

Table 1.1

Theory and hypotheses

		Do parties have core values?	
		Yes: Programmatic Parties	**No: Non-Programmatic Parties**
Do parties have programmatic commitment to the policy issue?	Yes: Core Values Related to Policy	**Agenda-setting** Parties introduce issue to the agenda.	*Not Applicable*
		Debate Parties shape policy specifications: (1) funding for reform's implementation and (2) infrastructure assessment. *High-quality legislation*	
		Implementation Specifications determine feasibility and sustainability of ensuring access.	
	No: Core Values Unrelated to Policy	**Agenda-setting** Technocrats introduce issue to the agenda.	
		Debate Parties do not shape policy specifications: (1) funding and (2) infrastructure assessment. *Low-quality legislation*	
		Implementation Lack of specifications hinders implementation due to instability of funding and shortage of infrastructure.	

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

Policy legacies and institutional constraints, such as federalism, also play a key role during both debate and implementation (Niedzwiecki 2018). Policy legacies can obstruct change (Pierson 1994, 2001; Brooks 2009; Rothstein 1998). Social security institutions can perceive an expansion of healthcare as a threat to their allocated resources (Ewig 2016). Interest groups, such as a strong private sector of healthcare provision and insurance, will oppose any expansion of the public sector that threatens their business. Overcoming such hurdles at every stage requires parties committed to the policy in question.

Research Design and Case Selection

The dependent variable of this study is the quality of the reforms enacted and implemented. I identify two types of policy specifications that policymakers define during the process of debate in Congress, which are crucial for the effective implementation of the reform if approved: (1) specifications regarding the *sources of funding* for the reform's implementation and (2) specifications regarding the need for an *infrastructure assessment* to establish the gap that the government needs to cover before the reform's implementation. The presence of these two key policy specifications defines whether legislation is considered high or low quality, and they are predicted to determine the feasibility of the reform during the next policymaking stage (implementation).

In this way, the book highlights the importance of policymakers' engagement in crafting policy specifications and the need for political

commitment to the sustainability of healthcare reforms. The presence of stable funding and the tackling of infrastructure gaps determine whether the implementation of the reform actually leads to better access to healthcare rather than just an increase in formal coverage. I evaluate the impact that these specifications crafted during debate have on the implementation by tracing the rollout of the reforms' implementation, with an emphasis on (1) the sustainability of funding, (2) the development of infrastructure, and (3) effective access to health services.[8]

To test my theory about how the relationship between a specific policy and the core values of parties affects the policy approved and its implementation, I use a small-N comparative analysis of the policymaking process of three healthcare reforms. These reforms, enacted in the 2000s in Latin America, aimed to expand access to healthcare services: universal access with explicit guarantees (AUGE) in Chile, Seguro Popular in Mexico, and universal health insurance (AUS) in Peru. My case selection primarily focuses on seeking variation across the political parties that promoted the reforms in

[8] It is important to recognize that the starting points of the three cases of study are different (i.e., the hurdle of infrastructure development in Mexico is greater than in Chile). However, a comparison in the rate of change across the three cases for the various indicators I include allows us a comparison of the quality of implementation.

terms of their programmatic nature.[9] Chile was one of the few Latin American countries where parties were considered strongly programmatic, whereas all major parties in Peru qualified as weakly programmatic (Kitschelt et al. 2010). The case of Mexico has more variation since two of its three main parties at the time were considered programmatic.

In Chile, Congress passed AUGE in 2004. The center-left Concertación coalition, formed by the Party for Democracy (PPD), the Socialist Party (PS), the Christian Democratic Party (PDC), and the Radical Social Democratic Party (PRSD), introduced the reform proposal. In opposition, they had the right-wing coalition Alianza, formed by the Independent Democratic Union (UDI) and National Renewal (RN). These parties relied on programmatic linkages to garner support from their electorate and on party programs to unify party leaders (Pribble 2013; Kitschelt et al. 2010). The Chilean parties were both programmatic and held core values related to healthcare reform.

In Mexico, the party in government, the right-wing National Action Party (PAN), presided over Seguro Popular. The Institutional Revolutionary Party (PRI) and the Party of the Democratic Revolution (PRD) were the main forces in the opposition. The reform was approved in 2003. Political parties in

[9] It is important to mention that the macroeconomic context of the three cases under study was different at the time when they approved their healthcare reforms. However, their economic growth patterns do not coincide with the occurrence of reform. See the case study chapters for further discussion.

Mexico varied, with the PAN and PRD relying more on policy programs than the PRI, which has been categorized as a patronage machine (Kitschelt et al. 2010; Magaloni 2006; Langston 2017; Greene 2007). Although PAN was a programmatic party, the core value uniting the party, Catholicism, did not relate to the healthcare reform. Furthermore, PRI had no core values uniting its leaders, and only a sector of PRD held core values related to the policy issue at hand.

The Peruvian Congress approved AUS in 2009. The government of the center-right APRA started its implementation.[10] As part of the opposition, there was a left-wing coalition between the Union for Peru (UPP) and the Peruvian Nationalist Party (PNP), as well as a right-wing coalition known as National Unity (UN).[11] The weak and electorally volatile Peruvian parties have been characterized by their reliance on charisma and clientelism rather than policy programs (Cameron 2011; Kitschelt et al. 2010; Levitsky 2013, 2018; Levitsky

[10] APRA was founded as a left-wing party in the 1920s, but it clearly veered to the right in the early 2000s (Tanaka 2008; Levitsky and Roberts 2011).

[11] The UPP–PNP coalition formed to support the presidential candidacy of Ollanta Humala in 2006, who lost the election to García but went on to become president in 2011. Unidad Nacional (UN, National Unity) was formed before the 2001 presidential election and presented Lourdes Flores as its candidate, who lost to Alejandro Toledo.

and Cameron 2003; Tanaka 2005). The Peruvian parties lacked core values uniting their leaders.

To engage in the comparative analysis, I first identify the main actors who place the issue on the agenda, observing the participation of political parties and technocrats during this initial stage of the process. Then, I trace the definition of policy specifications shaped during the debate as well as the actors responsible for them. Finally, I evaluate how the specifications regarding funding and infrastructure that the debate process arrived at impacted the implementation of the reforms, their sustainability, and, therefore, effective access to health services.

I conducted over 150 in-depth interviews with key actors from inside and outside the government, accessed archives from the legislatures and the executives, and collected statistics on the implementation of the three reforms. I included both structured and open-ended types of questions in my questionnaires. Interviews with actors who led the promotion and design of the reforms, such as health ministers, legislators, party leaders, and technocrats from the Ministries of Health, were crucial for the reconstruction of the policymaking processes. This reconstruction, however, would not be thorough enough without the interviews I conducted with ministers of finance, technocrats from the Ministries of Finance, representatives of private insurance and private provider companies, representatives of medical associations and international organizations, and policy experts.

I triangulated this in-depth information with transcripts of all the debates on the reforms that took place in the committees and floors of the Parliaments, as well as proceedings and reports. I identified the actors participating in the debates, as well as the arguments they used in support or against the proposals. I also accessed official documentation from meetings carried out in the Health and Finance Ministries. I supplemented the information gathered through interviews and government archives with data from secondary sources and newspaper archives to establish general timelines for the reforms under study and to cross-check the accuracy of accounts from interviewees. Finally, I collected data on population coverage by the different insurance schemes (public and private), general health budgets, government health expenditure per capita, human resources, and infrastructure development.

Key Findings and Contributions

A long list of factors, from resource scarcity to clientelism, has been cited as obstacles to social policy reform in Latin America. Nevertheless, reform has happened. In the last few decades, there have been several attempts to address the disparities present in Latin American healthcare systems, where socioeconomic status determines access. The quality of these reforms, which aim to expand access to healthcare, has varied. While one could focus solely on the success of a reform's implementation, this study sheds light on how the political process behind the formation of these reforms can significantly impact the prospects for increasing equality within the system.

The long-term goal of the healthcare reforms in Chile, Mexico, and Peru was quite similar: achieving an expansion of access to healthcare services, both in terms of the population as well as the treatment of different diseases. When examining the results of the reforms' implementation, we observe commonalities: each country experienced an increase in formal coverage and a general rise in state funding for health. However, there are relevant differences across countries: whereas the increase in funding for the health sector, public health expenditure (measured both per capita and as a percentage of GDP), and reform budgeting has been growing in Chile, it has been inconsistent or reduced in Mexico and Peru. Another key difference is that the growth in formal coverage of Chileans has been accompanied by a parallel development of the required resources (infrastructure and human resources) to provide services. This has not been the case in Mexico and Peru, leading to deficiencies in effective access to healthcare for the population.

The programmatic party's commitment to AUGE, which helped shape key policy specifications during the debate, facilitated sustainable implementation. The lack of commitment from the main political actors in the reform processes in Mexico and Peru led to poorly specified legislation and deficient implementation.

In Chile, the programmatic commitment of the left-wing coalition Concertación in government led the coalition to introduce healthcare reform into the agenda. In the opposition, the right-wing coalition Alianza sought to influence the reform in accordance with its core values: a market-driven

economy and a strong private sector. During the debate, both coalitions shaped AUGE's specifications according to their values, while pushing for a gradual implementation plan and long-term funding. However, PDC, part of the Concertación, joined the right to prevent the passage of the most solidaristic part of the bill. Although tensions existed between the PDC and the rest of the Concertación coalition, the programmatic commitment of the remaining coalition parties still led to a high-quality reform.

The analysis of the Chilean case revealed that the engagement of the main parties in crafting the specifications of AUGE forged a commitment of the parties to the sustainable implementation of the reform. Their political commitment, evident among party leaders in Congress, the central government, and at the local level, supported the development of infrastructure and the expansion of human resources for reform throughout the country. The Chilean reform is not exempt from limitations; for example, there are still differences in wait times between patients with AUGE pathologies and those with other pathologies. Nevertheless, the reform has provided widely available access to treatment for eighty-seven diseases (as of 2025), a situation not found in most countries in the region, including Peru and Mexico.

In Mexico, the programmatic party in power, PAN, which had Catholicism as the core value uniting its leaders, was disengaged from the policymaking process. PAN did not place the issue of healthcare reform on the agenda; instead, a small group of technocrats, led by Health Secretary Julio Frenk, presented the proposal to PAN. Although a few of these technocrats

were close to the PRI, none had ties to the PAN. Frenk and Funsalud – a think tank financed by the healthcare business sector – had worked on this proposal for almost a decade before Frenk became health secretary. The disconnect between PAN's core values and the reform led to a lack of programmatic commitment to the reform. PAN, as well as a PRI that lacked core values and a PRD where only a portion held a programmatic commitment to healthcare reform, had minimal participation in the definition of policy specifications. Instead, individual technocrats dominated the debate, which, in the context of disengaged politicians, led to legislation that lacked stable funding and a clear infrastructure plan.

During implementation, Seguro Popular fell short due to unstable funding, insufficient infrastructure, and low levels of commitment and accountability at the state level. Leaders from the three main parties in Mexico, at both the national and local levels, supported the reform due to the significant increase in resources for state governments that it entailed. However, when the implementation started, several state governments refused to contribute funds for it, and most states did not report how they used the federal government's funds. In contrast to Chile, there has been subnational political resistance to the implementation of healthcare reform, worsened by the lack of programmatic commitment. The lack of programmatic commitment from the Mexican parties hindered the implementation of reform. Seguro Popular ended in 2020, being replaced by a different program.

In the absence of policy programs across all major political parties in Peru, the emergence of a healthcare reform seeking to expand access to healthcare is incredibly puzzling. The Peruvian parties lacked both core values uniting their leaders and a connection to the issue of healthcare reform. They did not lead the agenda-setting process, nor did they participate in crafting policy specifications. Instead, technocrats from the United States Agency for International Development (USAID), without partisan ties, and representatives of the private sector not only introduced the AUS reform into the agenda but also dominated the debate process. Technocrats crafted a policy that was poorly specified for effective implementation, considering that provisions regarding funding and infrastructure were unnecessary during the debate stage and a risk to the bill's passage. The private sector representatives, who wanted to ensure that the reform would protect their interests, were very active during the policymaking process and collaborated with the USAID technocrats.

The Peruvian parties lacked programmatic commitment to the AUS reform and allowed the passage of low-quality policy. Implementation of this bill was slow during the first few years, due to the lack of funding and the infrastructure gap in the public sector. Although the fact that one of the USAID technocrats who had been involved since agenda-setting became health minister led to an increase in funding, the funds have not been stable. Moreover, a shortage of infrastructure and human resources constrains the provision of healthcare to those covered by the reform. The promoters of AUS

did not provide a plan to deliver a feasible and sustainable solution to Peru's healthcare access problems.

Like in the Chilean case, reforms can follow a *programmatic path*, in which parties with core values closely tied to the policy in question define a reform's specifications and commit to its implementation. Reforms can also follow a *technocratic path*, as was the case in Mexico and Peru, in which parties are not committed to the reform and hence do not engage in crafting key specifications for its implementation. Both paths can – and did – lead to reforms that increase formal coverage and health sector funding. The fundamental difference, however, is in the feasibility of ensuring access to healthcare and the sustainability of funding.

Although the ruling parties in Mexico and Peru supported the reforms under the leadership of their party leaders – President Fox and President García, respectively – they were predominantly disengaged from the discussion of the necessary specifications for implementation. The lack of participation by the main political parties during the debate implies a lack of commitment to the reform during its implementation, which hinders the reform's success. A policy designed by technocrats still needs to be carried out by committed politicians during its implementation to succeed. Although more people may enjoy formal coverage thanks to the healthcare reforms in Mexico and Peru, the shortage of means to effectively provide access to healthcare is a major obstacle.

The findings of this study contribute to the literature on social policy reforms by pointing out *how* the presence (or lack) of programmatic commitment affects policymaking and final policy. Moreover, expanding the study of healthcare reforms to cases in which non-programmatic parties carried out reforms allows us to further understand the role of technocrats and the private sector. The literature on technocrats in Latin America, which developed in the 1990s, primarily focused on the influence of technocrats on economic reforms through international and domestic organizations (Silva 2009; Centeno 1994; Centeno and Silva 1998; Williams 2006; Teichman 1997). This book brings technocrats back into the spotlight, exploring their involvement in healthcare reforms in post-neoliberal Latin America. I particularly distinguish between technocrats with and without partisan ties and the impact that this difference has on the policymaking process.

The degree of autonomy of technocrats in the health sector in many Latin American countries has changed over time. While technocrats enjoyed a great degree of autonomy during the 1990s, it decreased in the early 2000s when international financial institutions (IFIs) started to lose interest in healthcare reform (Dargent 2015; Ewig 2010). However, during the policymaking process for the reforms in Mexico and Peru, technocrats without partisan ties were again given high levels of autonomy, which allowed them to dominate the policymaking process.

Multiple studies have demonstrated that programmatic parties are highly relevant to democracy and representation in the region (Levitsky and Cameron

2003; Mainwaring 2018; Mainwaring and Scully 1995). Some of these studies have also suggested that programmatic parties can be important for policymaking, although this connection has not been further explored. The gender policy literature has shown that programmatic left-wing parties are more likely than the non-programmatic left to foster gender equality and reproductive rights (Blofield, Ewig, and Piscopo 2017; Blofield and Ewig 2017). I contribute to this literature by examining the circumstances under which programmatic parties influence policymaking and the final policy, with a focus on healthcare. More broadly, this study highlights the need to bridge the literature on social policy and the literature on political parties, as well as the importance of careful analysis that disentangles the mechanisms through which political parties influence policy.

Understanding how policy is made differently in countries with parties without policy programs versus countries where parties are programmatic sheds light on why policies that promise significant improvements in healthcare access fail to deliver. Although this study focuses on Latin America, its findings have implications for countries beyond the region, where parties without policy programs are present and influence policymaking and policy outcomes. The possibility of high-quality social policy reforms in such countries is low.

Structure of the Book

The rest of the book is organized as follows. Chapter 2 presents the theoretical framework and the research design of the study. It sets expectations for agenda-setting, debate, and implementation based on whether the core values of the political parties involved in the reform process relate to the policy issue at stake. It then describes the operationalization of dependent and independent variables, the process tracing approach used to collect evidence, and the logic of the case selection employed in this study. Chapter 3 presents a comparative analysis of the process of reform in Chile, Mexico, and Peru. The chapter demonstrates that reforms seeking to expand access to healthcare can follow a *programmatic path*, in which parties whose core values are related to the policy issue hold a programmatic commitment to defining the specifications of the reform. In the absence of political parties interested in the prospect of reform, technocrats can dominate the policymaking process, in a *technocratic path* to reform. With parties disengaged from the definition of policy specifications and without political commitment, this path can lead to poorly designed legislation and deficient implementation. One of the most relevant distinctions between the two paths is the feasibility of ensuring access to healthcare and the sustainability of funding that the programmatic path grants. This chapter also briefly discusses the shortcomings of alternative explanations to help us understand the variation in policy quality across the three cases under analysis.

Chapters 4 through 6 examine the policymaking process of healthcare reform in each case. Chile, where the programmatic commitment of the parties

led to a clear definition of specifications and thus a feasible and sustainable implementation, is the focus of Chapter 4. Chapters 5 and 6 are devoted to the analysis of Mexico and Peru, respectively, where the lack of programmatic commitment to the reform led to poorly specified policy and deficient implementation. Each chapter is divided into agenda-setting, debate, and implementation. I demonstrate that the participation and impact of programmatic parties on the policymaking process of reforms depend on whether the parties' core values are related to the policy issue under debate. Moreover, I show that in a context of lack of commitment from the main political actors, technocrats dominate policy formation at every stage of the process, from agenda-setting to implementation. Chapter 7 concludes by providing a discussion of the significance of this study's main theoretical and practical implications.