Two Paths to Reform: Political Parties and Technocrats in Latin American Healthcare Policy

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Abstract

Over the last decades, Latin American countries have attempted to universalize access to healthcare and thus ameliorate a system that discriminates based on the socioeconomic status of their citizens. Existing literature has focused on the responsibility of strong left-wing parties for the expansion of social benefits, overlooking the development of reforms by non-left parties. This paper compares two processes of healthcare reform that took place with right-leaning parties in power (Mexico and Peru) and one under a left-wing coalition (Chile) in the 2000s. I argue that the programmatic commitments of parties, only present when a party has core values that unite its leaders and a policy issue relates to such values, affect the quality of legislation. These commitments shape the specifications of a reform regarding implementation and funding. Reforms can follow a *partisan path*, in which parties with values closely tied to the policy issue define a reform's specifications. Reforms can also follow a *non-partisan path*, in which parties disengaged from the definition of specifications allow technocrats to dominate the policymaking process. Both paths can lead to reforms that increase formal coverage and even funding of the health sector. The key difference is in the feasibility of ensuring access to healthcare and the sustainability of funding. This study is based on 12 months of extensive field research in Chile, Mexico, and Peru, during which I conducted over 150 in-depth interviews with political elites, technocrats, and leaders of interest groups, and collected quantitative measures of the implementation of the reforms.

Reforms seeking to universalize access to social benefits promise to alleviate social inequality. Yet, the political process behind the formation of these reforms can severely affect the prospects for tackling these disparities. Over the last decades, several Latin American countries have attempted to universalize access to healthcare and thus ameliorate a system that discriminates based on the socioeconomic status of their citizens. Existing literature has focused on the central role played by strong left-wing parties in the expansion of social benefits. Such an approach has overlooked the development of reforms in countries where, instead, non-left parties supported and implemented reforms seeking to universalize access to healthcare. This paper compares two processes of reform that took place with right-wing leaning parties in power (Mexico and Peru) and one under a left-wing coalition (Chile) in the 2000s.

It has been argued that the presence of programmatic parties (Stein & Tommasi 2007) as well as party system institutionalization (Scartascini et al. 2009) can help explain policy reform. Based on this literature, we would not expect to find healthcare reform in Peru, a country with parties characterized by the use of charismatic and clientelistic linkages rather than policy programs (Cameron 2011, Kitschelt et al. 2010, Levitsky 2013, Tanaka 2005). Moreover, these studies do not look at the process behind *how* programmatic parties affect policymaking.

Programmatic parties have core values that unite their leaders and drive the party program. Whereas certain policy issues are directly related to the core values of a party, others are not. I argue that having programmatic parties is not sufficient to explain the participation and impact of parties in policymaking, but what determines the programmatic commitment of parties is whether a specific policy relates to the core values of parties.

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

Reforms seeking to universalize access to healthcare can follow a *partisan path*, in which parties with values closely tied to the policy issue play a central role in defining the

specifications of the reform. Reforms can also follow a *non-partisan path*, in which parties disengaged from the definition of specifications of a reform allow technocrats to dominate the policymaking process. Both paths can lead to reforms that increase coverage and even increased funding for the health sector. The key difference is in the feasibility of ensuring access to healthcare and the sustainability of funding.

This study is based on 12 months of extensive field research in Chile, Mexico, and Peru, during which I conducted over 150 in-depth interviews with political elites, technocrats, and leaders of interest groups, and collected quantitative measures of the implementation of the reforms. Its findings contribute to the literature on social policy reforms by pointing out *how* the lack of programmatic commitments of political parties affects the policymaking process and final policy. More broadly, my research demonstrates the need to bridge the literature on social policy and political parties, and the relevance of careful analysis that disentangles the mechanisms through which parties affect policy.

Healthcare in Latin America

A key feature that defines healthcare in Latin America is inequality: citizens with formal jobs have access to a healthcare scheme through salary contributions, whereas those within the informal economy (over 50% of the Latin American population) are usually unprotected. Reforms seeking universalization have taken place in Argentina, Brazil, Chile, Colombia, Mexico, Venezuela, Peru, and Uruguay. These reforms, however, have been different: some more expansive than others, with more or less planning behind them, some more sustainable than others. *What determines the different types of reforms implemented and their different degree of success?* In other words, *what explains the difference in quality of healthcare reform?*

An important body of literature has focused on the role of left-wing political parties, arguing that strong leftist parties are responsible for the effective universal expansion of social benefits (Esping-Andersen 1990, Huber & Stephens 2001, Murillo 2005, Pribble & Huber 2013). Such an approach overlooks the development of reforms promoted and carried out by right-wing parties, disregards features of parties that can influence the policymaking process apart from ideology, and overlooks the role of other actors such as private insurance and provider companies. Based on this body of research, we should expect the development of health reform in countries such as Uruguay and Chile, but be surprised by the same phenomenon in countries like Peru and Mexico.

Another factor that scholars find to be strongly associated with social policy reform is economic development, as wealthier countries have more funds available for social expenditure (Segura-Ubiergo 2007). However, countries with the same level of economic development choose different types of social policies, both in high-income (Esping-Andersen 1990, Huber & Stephens 2001) and low-income countries (Filgueira 2007, Huber & Stephens 2010). In Latin America, episodes of social policy expansion have occurred both at times of economic growth and of economic crisis (Garay 2016). Previous studies that focus on budgets, and not necessarily on the quality of the policy approved, do not address the importance of engagement from congressmen and other policymakers in crafting the different specifications of the reforms.

Literature on democratization asserts that democracy is beneficial to the expansion of social protection (Przeworski 2000, Sen 1999). By opening a channel to demands from different groups, especially those being excluded from the provision of benefits, democracies respond to the needs of their citizens through pressure (Haggard & Kaufman 2008, Filgueira 2007, McGuire 2010). Along these lines, Garay (2016) finds that the presence of electoral competition and social mobilization can explain the expansion of social policy in the region. As Garay (2016) points out, in Peru neither of these variables was present. How then can we explain the development of reform attempting to universalize access to healthcare?

Finally, diffusion theory expects policy innovations to spread across countries (or local units), as foreign models captivate policymakers, based on political self-interest and using inferential shortcuts (Weyland 2009) or based on ideological commitments (Borges Sugiyama 2013). However, the complexity of some reforms, such as universalizing access to health (Kaufman & Nelson 2004) makes it harder for policymakers to just borrow blueprints.

Political Parties and Policymaking

The literature on political parties has stated their importance for democracy and representation (Aldrich 1995, Levitsky & Cameron 2003, Mainwaring & Scully 1995). It has also suggested that parties can be important for policymaking, without exploring the connection between the nature of parties and policymaking. Parties can play key roles as policymakers.

A party feature that has been deeply explored is ideology. Along a left-right ideological spectrum, we can position parties based on their views on the need for state intervention to generate equality and social inclusion (Levitsky & Roberts 2011). Scholars find the ideology of parties to be pertinent to the allocation of attention towards certain issues and thus for public

spending (Blais et al. 1996, Castles 1982, Huber & Stephens 2012). We can expect leftist parties to be more inclined to pay attention to and spend on the development of the welfare state and the generation of equality than right-wing parties. How do we explain the development of reforms seeking to universalize access to healthcare promoted and carried out by right-wing parties?

Perhaps the answer is found in the programmatic nature of parties. Some studies have pointed out the importance of party system institutionalization (Scartascini et al. 2009), as well as programmatic parties in Latin America (Stein & Tommasi 2007) for the quality of public policy. Using large N quantitative analysis, these studies do not look at the process that can explain *how* programmatic parties affect policymaking.

Programmatic parties are organized around a coherent set of policy alternatives and appeal to citizens on the basis of policy programs (Kitschelt et al. 2010). Programmatic parties have a vision of how society should be organized, an analysis of what the most pressing problems in a society are, as well as a plan to solve them and thus get closer to an ideal. We can distinguish two components in the programmatic nature of parties: (1) programmatic unity of its leaders and (2) programmatic appeals to voters. When studying parties as policymaking actors, it is the first component that deserves further evaluation.[1] A party *is* programmatic when it has core values that unite its leaders. These core values are the values that parties care about the most and therefore unite parties organically; they drive the program of the party. I argue that *being* programmatic is not sufficient to explain the participation and impact of parties in the policymaking of healthcare reforms.

A party can hold core values regarding key issues such as a state-run versus market-led economy or a Catholic versus secular state, but what determines the ***programmatic commitment*** of a party is whether a specific policy relates to the core values of the party. Certain policy issues are directly related to the core values of a party, whereas others are not. If a policy lacks connection to the core values of the party, there will be no commitment to that policy, neither to the definition of its specifications or its implementation.

In this sense, being programmatic does not equate to having a programmatic commitment to every policy issue. If a policy is not related to the core values of the party, the programmatic commitment is absent. In that context, other factors will determine the support or opposition of

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

the members of the party. For instance, they might support a policy for the resources that it entails or oppose it because it could harm their ability to enforce patronage, or they may want to influence more detailed provisions (i.e. in the case of heath reform, the possible access to contraception).

In the case of a policy proposal that looks to universalize healthcare access, if the values of equality and social inclusion are a core value of a party, since this value is related to universal healthcare, the party will hold a programmatic commitment to shaping the policy in alignment with such values: promote reforms with a broad scope of coverage. If a free market is a core value of the party, the party will hold a programmatic commitment to shaping the policy in alignment with this core value: promote minimal state intervention in the health system and the participation of the private sector. Instead, if Catholicism is a core value of the party, since a proposal looking to universalize access to healthcare does not affect this value, the party will not hold a programmatic commitment to shaping the policy specifications. We must think of the programmatic nature of parties in a more differentiated manner by policy issue, instead of simply whether a party is either always programmatic or not.

Then, how do we explain healthcare reform in cases where parties' core values do not directly relate to this policy issue? Moreover, how do we explain reform in the context of parties without core values, which have no commitment to the policy? Actors outside the government, such as think tanks, international organizations, or individual technocrats from these groups will play a key role in these cases. Therefore, we can expect to have reforms following a *partisan path*, in which parties with core values directly related to the policy issue play a central role in defining the specifications of the reform. Reforms can also follow a *non-partisan path*, in which parties disengaged from the definition of its specifications allow outside actors to dominate the policymaking process.

The policymaking process can be laid out in different stages: agenda-setting, debate, and implementation (Jones & Baumgartner 2005, Kingdon 2010). The presence or absence of parties' programmatic commitments to a policy affects the process of policymaking at its different stages. During the **agenda-setting** stage, it determines whether political parties or actors outside the government lead the agenda-setting process. If a policy issue relates to the core values of a party, the party will introduce the issue to the agenda. If the issue does not relate to the core values of any of the parties, we will see actors outside the government placing the issue

into the political agenda. Table 1 shows the impact of the presence of programmatic commitments on the quality of healthcare legislation by tracing the effect across the three main policymaking stages.

Table 1 Theory and Hypotheses

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

During the process of **debate**, the programmatic commitments of parties are highly relevant as they determine the specifications of the bill regarding implementation and funding. When the reform proposal is directly related to the core values of a party, the party attempts to shape the proposal according to its programmatic commitments. On the contrary, if the issue is only

tangential to such core values, the party does not care for the specifications of the bill, thus generating poor quality legislation. The participation of parties, shaping the different specifications of the bill, helps to generate a commitment to the reform before its implementation.

Finally, during **implementation**, the specifications of the bill shaped during the process of debate determine the feasibility of ensuring access to healthcare as well as the sustainability of the project in the long-term. On the other hand, when this participation is absent, 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.

Research Design

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

In order to test my theory, I use a small-n comparative analysis of reforms aiming to universalize access to health services. I trace the policymaking process of three reforms that were enacted in the 2000s. The Mexican and Peruvian reforms were promoted and implemented by right-leaning parties, whereas it was a left-wing coalition in Chile. Together with the ideological orientation of the parties that promoted the reforms, my case selection concentrates on seeking variation in the different type of parties present in each country. Chile is one of the few Latin American cases where parties are considered strongly programmatic, whereas all major parties in Peru qualify as weakly programmatic (Kitschelt et al. 2010). The case of Mexico is mixed since two of its three main parties are considered programmatic.

Table 2 Case Selection

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

In Chile, Universal Access with Explicit Guarantees (**AUGE**) passed a vote in Congress in 2004. The center-left Concertación coalition, formed by the Party for Democracy (PPD), the Socialist Party (PS), the Christian Democratic Party (PDC), and the 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 gain support from their electorate (Pribble 2013, Kitschelt et al. 2010). The healthcare reform was related to the core values of Chilean parties.

In Mexico, the party in government, the right-wing National Action Party (PAN), promoted Seguro Popular (**SP**); 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 Mexico are varied, with PAN and PRD relying on policy programs more than PRI, which has been categorized as a patronage machine (Kitschelt et al. 2010, Magaloni 2006). The healthcare reform did not relate to the core values of PAN, and only a sector of PRD held core values related to the policy issue. PRI had no core values uniting its leaders.

The Peruvian Congress approved Universal Health Insurance (**AUS**) in 2009. Although the party in power, the Peruvian Aprista Party (APRA), had originated as a left-wing party in the 1920s, it shifted towards the right in the subsequent decades. As part of the opposition, there was

the left-wing coalition between Union for Peru (UPP) and the Peruvian Nationalist Party (PNP), as well as the right-wing National Unity (UN).[2] The weak and electorally volatile Peruvian party system has been characterized by the use of charismatic and clientelistic appeals (Cameron 2011, Levitsky 2013, Tanaka 2005).

I trace the policymaking process of the reforms through in-depth semi-structured interviews with key actors from inside and outside the government, including former health ministers, legislators and party leaders, technocrats from the Ministries of Health and Finance, representatives of private insurance and provider companies, of international organizations, and policy experts. Moreover, I accessed archives from the Legislatures and the Executives as well as statistics on the implementation of the three reforms.

In order to measure the presence of core values for the parties, I look at their positions on whether an economy should be regulated by the state or the market, which can show the level of agreement present among party leaders. This data was collected by the Parliamentary Elites in Latin America (PELA) study, a series of surveys conducted with members of parliament in the 2000s (Alcántara 2012).[3]

Agenda-setting

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

[2] The UPP-PNP coalition was formed to support the presidential candidacy of Ollanta Humala in 2006, who lost the election to García but went on to become president in 2011. UN formed before the 2001 presidential elections and presented Lourdes Flores as its candidate.
[3] Observatorio de Élites Parlamentarias de América Latina http://americo.usal.es/oir/elites

population bought a private insurance (3%), affiliated to a special scheme for the poor (24.5%), or just remained unprotected (50.5%).[4]

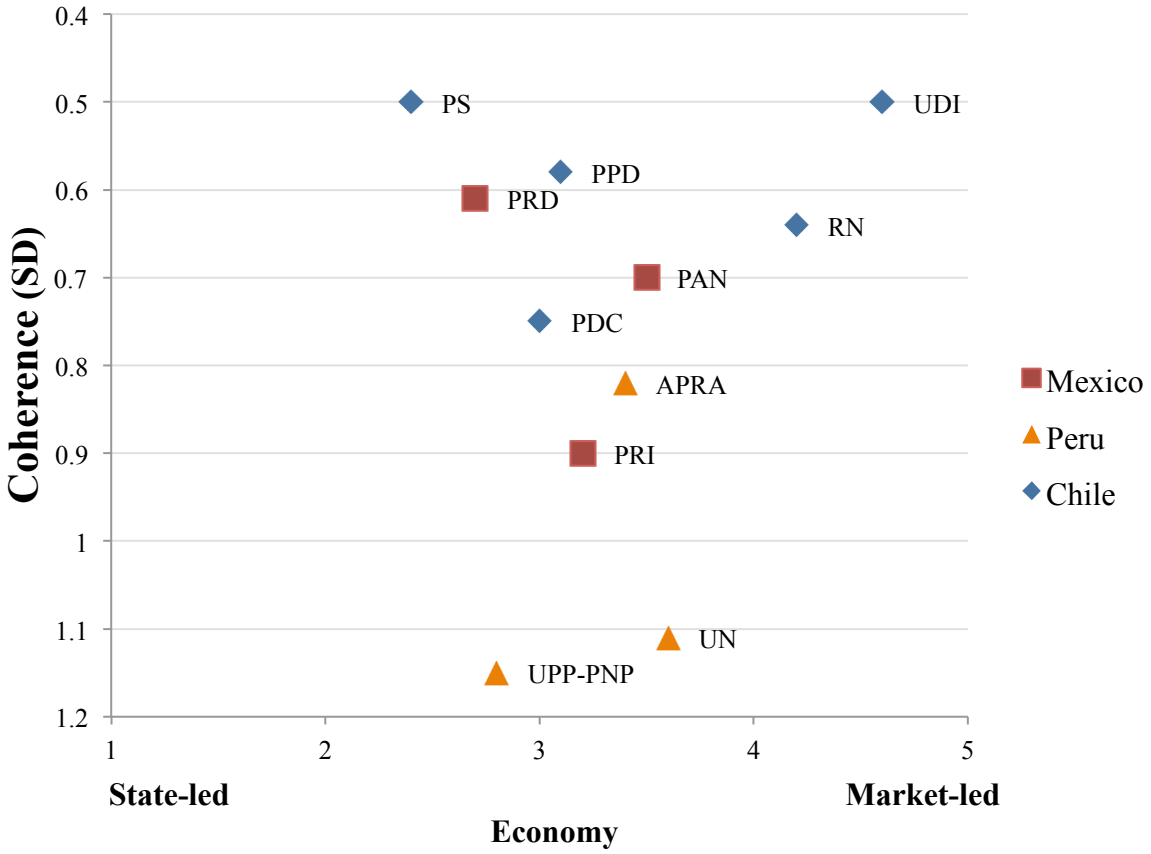
The health reforms introduced in the 2000s in these countries shared two main long-term goals: 1) universal coverage of the population, which was particularly important in the cases of Mexico and Peru, and 2) gradually increasing coverage of health conditions by guaranteeing access to treatment for a set of diseases, and hence level the benefits across schemes. The reform process in the three countries was very different with regard to the involvement of parties, as was the quality of the legislation produced. In Chile, political parties were closely involved at all stages of the process, as the reform connected with their core values; in Mexico, PAN, a programmatic party, was marginally involved because the reform was not related to its core values; and in Peru parties did not have core values that united them and thus were not involved. As a result, in Mexico and Peru, technocrats rather than parties placed the issue into the agenda and there was a lack of commitment from the main parties to the reforms.

The positions of members of parliament representing the different parties, on whether an economy should be regulated by the state or the market are indicative of the parties' consensus on these values. As figure 1 shows, there is more cohesion among the Chilean parties, in comparison to their counterparts in Mexico and especially Peru. The least coherent party in Chile, PDC, is still more coherent than the most coherent party in Peru, APRA. Chilean parties are coherent on the role of the state, not just regarding the regulation of the economy but also in the provision of social benefits. Whereas the survey of members of parliament did not ask about social benefits, evidence from interviews with politicians suggests that they also cohere on the role of the state in providing social benefits (Pribble 2013).

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

[4] The remaining 2% was affiliated to the Military and Police Health System.

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



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

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

The Health Department (MINSAL) submitted the AUGE bill to Congress in May 2002. AUGE had the main goal of bringing more equity to the system, which would be achieved by giving patients rights and guarantees for a prioritized set of health interventions. The bill included the creation of the Health Superintendency, to monitor public and private health providers as well as insurers (FONASA and Isapres).[5] In June, they sent the Financing Law bill, which would establish the financial resources for the reform. During the agenda-setting process, parties in Chile were committed to the introduction of healthcare reform into the agenda.

In the case of Mexico, the right-wing PAN in government, had a key core value uniting its members: Catholicism. However the health reform was tangential to this core value. Consequently, PAN did not introduce the issue into the agenda nor shaped the specifications of the reform but only supported it under the command of its leader, President Vicente Fox. Both members of the Health Secretariat as well as of PAN agree that there was no participation of the party. Health was not a key issue of PAN's agenda neither during the electoral campaign or the first years of government.[6]

Health Secretary Julio Frenk introduced the health reform proposal into the political agenda in 2000. Frenk did not have any partisan affiliation, although he was close to PRI but not to the party in government, PAN. Frenk had worked on this proposal since the early 1990s for the Mexican Foundation for Health (Funsalud), a think tank that had been actively involved in the design of health policy during the PRI governments since the early 1980s.[7] (See the appendix for a full description of the agenda-setting process in Mexico).

SP would provide protection to those without insurance (known as the "open population" in Mexico) with a set package of benefits for certain health conditions. Frenk formed a small group of people in charge of SP's design. For the team, having a set package of benefits was important in order to make the right to these benefits explicit and determine how much money they would need. In November 2002, the Executive sent the bill to the Senate, which also included the

[5] The commission also introduced modifications to the Isapres Law (18.933) in order to increase the regulations imposed on them, and the Financing Law that would establish the financial resources for the health reform.
[6] Neither were education and even the fight against poverty.
[7] Funsalud is financed by the health business sector; its board of directors includes representatives of the National Association of Private Hospitals and the Mexican Association of Insurance Institutions. As a member of the organization noted, "*Funsalud has always been a relevant player in the health policy of the country, especially because it has financing from the main businesses of the country.*"

creation of the National Commission for Social Protection in Health (CNPSS) to be in charge of implementation.[8]

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

The Peruvian political parties lacked core ideological values uniting their members. Consequently, they did not behave programmatically in response to the prospect of a health reform (AUS). An outside actor, a USAID funded project, was responsible for the introduction of AUS into the political agenda. The USAID project, PHR*plus*, had worked on AUS since 2004, together with a plan of benefits and guarantees of health services to which those insured would have access. A member of the USAID Health Office in Peru during that time noted that the agreement was important for USAID, as it was a highlighted point when asking for funds from donors. AUS became a flagship USAID plan. (See the appendix for a full description of the agenda-setting process in Peru).

Although different parties introduced bills on the issue, in the case of APRA and UN, the content of these bills was a product of a few advisors and consultants from the USAID project and the private sector. An advisor of UN noted that they asked members of PRAES, the continuation of PHR*plus*, for help in crafting the bill. A key member of PRAES who coordinated with the parties' representatives, Oscar Ugarte (who later became health minister), noted: "*AUS was proposed by PRAES and then taken on by UN and APRA.*" The right-wing APRA also introduced a bill, which proposed a package that would establish the benefits and guarantees of health services that all insurance institutions, public and private, would be bound to fulfill (called

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

PEAS). PRAES members as well as Health Department (MINSA) officials stated in my interviews that PEAS was a product of the USAID funded groups, which had worked on it since 2004. Moreover, one of APRA'S main advisors noted that "*PRAES already had an outline of how AUS should be.*"

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

Debate

The prospect of a healthcare reform that aimed to universalize access to healthcare was directly related to the core values of the Chilean parties, and hence they were committed to defining the specifications of this policy. Whereas the center-left looked to move the health system closer to the goal of equity, the right sought to defend the interests of the private sector. A point of convergence, however, between left and right was their interest in a feasible process of implementation for AUGE. The role that parties had as policymakers during this process, behaving programmatically, can help us to understand AUGE in terms of its specifications regarding financing and implementation, which determined the sustainability of the reform in the long term. Even though there were differences within Concertación, there was a programmatic commitment of their members to the need of a reform that could bring equity and could be implemented. In Peru and Mexico, there was no political commitment to the reform.

If we think of the Mexican parties through a dichotomous frame (programmatic or not), we would expect PAN to behave programmatically. However, the health reform was not directly related to the core value of the party, Catholicism, and hence the party lacked programmatic commitment to the reform. This defined the process of debate and also the content of the final law that was approved. In the words of a member of the SP team, "*the legislature did not introduce any important changes.*"[9]

[9] Then HC President Galván (PAN) noted that the meetings they held with Secretary Frenk and other members of the SP team were not necessarily discussions, rather meetings "*to create awareness and review legal details*".

In Peru, parties that lacked core values and hence had no programmatic commitments to the reform approved a law that lacked specifications regarding the necessary funding to be implemented. AUS promoters preferred to avoid discussions on infrastructure and funding because these issues were considered controversial and could put at risk the passage of the law. In the words of the main HC advisor, this followed "*the norm that 'big policies' are not approved in Congress, but 'small' ones that are easy to understand*".

Technocrats filled the void that the lack of participation of the parties left in Peru and Mexico. Technocrats, instead of party representatives, were the protagonists of the processes of debate. In the case of SP, technocrats from Funsalud, a think tank financed by the private sector, introduced the reform into the agenda. Health Secretary Frenk, former Funsalud leader, led a group of experts that controlled the process of debate around the reform. In Peru, technocrats from USAID funded projects led the process of debate on AUS. Three of these consultants later became health ministers in the country. Technocrats also participated in Chile, but they were not isolated from the platforms the Concertación government proposed. Most of them had partisan affiliations within Concertación, which meant they followed the programmatic guidelines of the coalition. The role technocrats have during policymaking depends on the type of parties. If the parties behave programmatically, technocrats serve the purpose of developing specific goals. If parties behave non-programmatically, technocrats dominate the process, which can lead to the introduction of poorly specified bills.

Chile

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

Concertación faced the opposition of the right-wing Alianza and their reluctance to accept the Solidarity Fund (SF), a mechanism of redistribution across affiliates of the public and private sectors, which would take 3% of the 7% compulsory contribution workers made (to either FONASA or Isapres), and then give back to the affiliates adjusting for their risk based on sex and age.[10] Alianza represented the position of the Isapres Association. Isapres made it clear that they strongly opposed the SF. The fund implied an estimated net transfer of around 15 billion Chilean pesos (22 million USD) from Isapres to FONASA (Blackburn et al. 2005). The association's Research Manager Gonzalo Simon noted that the fund "*caused panic among Isapres*" as they began to perform internal calculations of how the size of their market share would decrease. There was a close relationship between Isapres and the right-wing parties, through which the association provided information to Alianza senators.[11]

The veto Alianza could impose during floor debate in the Senate was a latent threat. Several interviewees noted that Alianza made it clear that they would veto the reform on the floor and therefore the fund had to be removed from the bill. As then health policy advisor to the Treasury, Consuelo Espinosa, put it: "*We had to sacrifice the fund… otherwise the whole reform would have fallen*." Then health minister García noted that the SF "*was only 16 billion pesos [around 30 million USD]; AUGE could have fallen because of it… It was marginal… Why get into a fight and risk losing it all*?" AUGE, nonetheless, eliminated the vulnerability of private sector members with regard to the 56 diseases the plan included. For the first time since Pinochet's regime created Isapres, the government was able to impose on them the obligation to provide a minimum coverage to their affiliates. The law also established limits to the co-payments affiliates would pay for AUGE diseases (in FONASA and Isapres).[12]

The funding of the health reform was an important part of the discussion. The Financing Law was enacted in August 2003. AUGE was to be funded through a 1% increase of VAT, increased efficiency in the use of health funds, government revenues, and a new universal premium. The reform commission, in collaboration with MINSAL's Epidemiology division,

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

[11] Isapres' representative Simon recounted that congressman Alberto Espina (RN) "*came every week, for 2 hours, to understand the operation of the [health] system before the start of the discussion*".

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

calculated the cost of the universal premium that would be taken from the current premiums of affiliates to the public and private sectors. The Treasury is obliged to give resources to AUGE, based on this premium, which has made AUGE sustainable over time. The Treasury showed commitment to fund AUGE from the beginning. Former Superintendent of Health Manuel Inostroza emphasized that AUGE specifications guaranteed resources, diminishing the power of the Treasury. The law established the set of prioritized diseases to be re-evaluated every 3 years in order to progressively include more diseases that, according to epidemiological studies, were a priority to cover.

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

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

Mexico

The ruling party, PAN, gave its absolute support to the SP bill, but it had no participation in the definition of its specifications. For one of the SP team members, the lack of participation of PAN was a lucky thing because these politicians "*would have contaminated [the process]*". The SP team was a very closed group, with very little participation from other members of the Health Secretariat.[13] In the words of PAN Deputy and HC President María Galván, "*PAN gave all its support to Dr. Frenk's initiative.*" All PAN members voted in favor of the bill in both houses. However, the party did not have enough votes to pass the bill and hence needed the support of legislators from the other two main parties: PRI and PRD.

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

For several PRD members, SP would lead to the gradual privatization of the health system since the public sector would not be able to cover the demand for services alone. They also considered that having a package of interventions for specific health conditions was discriminatory to those who suffered illnesses outside of this set. The Frenk team tried to "reconcile" the first point and stated in the bill that only public institutions could provide services for SP, but, in the words of then Legal Affairs Director at the Health Secretariat, Ignacio Ibarra, "*the play was to include it in one part [of the bill] but not in the other.*"

PRD never presented an alternative to SP, but a sector of PRD advocated for a national system, an increase of public funding and strengthening the public provision sector so that everyone could access free services. PRD was divided at the time of the vote in the Senate in April 2003. The PRD sector in favor of SP supported the important increase in resources that would reach the states thanks to the reform. The governors were convinced that SP would bring more resources to their states. In the words of then PRD member Oliva López, "*that was the carrot for governments strangled by the lack of resources… those senators had a pragmatic position.*" (See the appendix for a full description of the debate process in Mexico).

PRI votes were extremely important to approve SP (they held 60 out of 128 seats in the Senate). Members of the Frenk team noted how much work they put into lobbying PRI representatives. PRI did not shape the law as a party, but individual PRI legislators introduced some additions related to their particular interests. An important addition from Senator Navarro Quintero was an article stating that 3% of the resources destined for SP had to go to the development of infrastructure. SP had partial support of PRI.[14] A key factor that won PRI's support was the large increase in resources for state governments that SP entailed, which have always been important for patronage.

A point of PRI opposition was tied to the Treasury. Then Deputy Jorge Chávez (PRI) noted that several PRI deputies "*acted in coordination with certain institutions such as the Treasury, IMSS and their state governments*." The Treasury felt that there were not enough resources for SP. Even though then Treasury Secretary Francisco Gil (PRI) remained removed from the process, Sub-secretary Carlos Hurtado did "*the front line battle*", as he called it. Hurtado stated: "*In theory, if Fox sent the bill, his ministers were on board… but it was not the case, we [the*

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

Treasury] hijacked the proposal." He also noted that one of President Fox's advisors called him to say it was enough and Secretary Gil instructed him to stop the resistance in the Senate. The arrangement was that the bill had to include a transitory article stating that families would be affiliated to SP in a gradual manner.

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

The SP team had decided that the unit of insurance was going to be the family, in order to mirror the social security system schemes. Also mirroring IMSS and ISSSTE, SP would have 3 main sources of funding: 1) Social Contribution (CS) per family, paid by the federal government, 2) State Solidarity Contribution (ASE) paid by the state governments, and 3) Federal Solidarity Contribution (ASF).[15] However, several governors showed reticence to provide the State Solidarity Contribution (ASE) once the law was approved.

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

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

[15] CS was established to be 15% of a minimum salary in the Federal District. The ASE was 0.5 times the social contribution, whereas the ASF was 1.5 times the social contribution.

Peru

In September 2008, the HC in Congress discussed AUS for the first time. At the HC, two main advisors were in charge of an AUS working group; one of them was Aníbal Velásquez, from the USAID funded project PRAES. Then president of the HC, Wilson (APRA), noted that the point of these meetings was to generate consensus between the different actors involved. However, those who represented the opposition to AUS disagreed and argued that the meetings were mainly to convince them, that "*they were monologues of PRAES people… they were not debates but presentations.*"

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

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

During the HC meetings and on the floor, the funding of AUS failed to become the center of discussion. AUS was going to require a good amount of funding for two main areas: strengthening the supply side (mainly infrastructure and human resources) and financing the demand (the state would cover the services for poor people completely and partially for those with some acquisitive power). Surprisingly, not much debate went into how to fund this ambitious proposal. In the Executive, the issue of funding did gather more attention. According to then Health Vice-minister's advisor, who was in charge of the meetings between MINSA and the Ministry of Economy and Finance (MEF), "*the main question MEF had was how are you going to do this? But that had not yet been designed. There was no financing plan.*" The advisor also noted that the agreement they reached was that "*MINSA would make do with what they were given.*" Both the vice-minister and minister of health at that time concurred that they settled for this agreement and expected to get money in the future.

If the AUS bill did not specify the amount of monetary resources needed, neither did it specify the sources. The bill only mentioned that the funds would come from general taxes and APRA legislators emphasized that the Executive would be in charge of determining the details once AUS was approved. Moreover, several AUS promoters emphasized that engaging in a discussion about funding and its sources was going to put the passage of the law at risk. The former health ministers as well as the UN and APRA legislators noted that the context of consensus that was achieved had to be used to launch AUS, even though that meant not having secure funding. In the words of former Health Vice-minister Melitón Arce (APRA), "*AUS had a lot of pragmatism.*"[16]

AUS passed a vote in Congress in March 2009. Surprisingly, one of the left-wing parties that had opposed the reform since the beginning, UPP, on the grounds that it promoted a fragmented system and the expansion of the private sector, voted in favor of the law. The health minister at the time noted that they "*convinced UPP.*" The advisor to UPP leader Francisco Escudero explained that Congressman Wilson and the health minister convinced Escudero of the positive sides of AUS. Wilson's advisor's account varied from this. He noted that they agreed with Escudero on UPP voting in favor of AUS and then APRA would vote in favor of a law Escudero had been trying to pass for a while. Right after AUS passed, the discussion of Escudero's bill was included in the HC agenda "with priority" and finally approved with the votes of all APRA legislators. (See the appendix for a full description of the debate process in Peru).

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

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

well as its sustainability. This lack of commitment of the most relevant political actors proved to be costly during implementation.

Implementation

The long-term goal of the healthcare reforms in Chile, Mexico and Peru was largely similar: achieving universal access to healthcare services, both in terms of the population as well as treatment of different diseases. When we look at the results of the implementation of the reforms, we see commonalities. There was in increase of people covered, as shown in table 3, in the three countries. It is important to point out that although Chile had over 90% formal coverage before the reform, as Pribble (2013) has documented extensively, there were still important barriers to effective access. In the cases of Mexico and Peru, although we see a considerable increase in formal coverage, we must be cautious in considering this an indicator of success as the constraints to effective access of people covered "on paper" has gotten in the way.

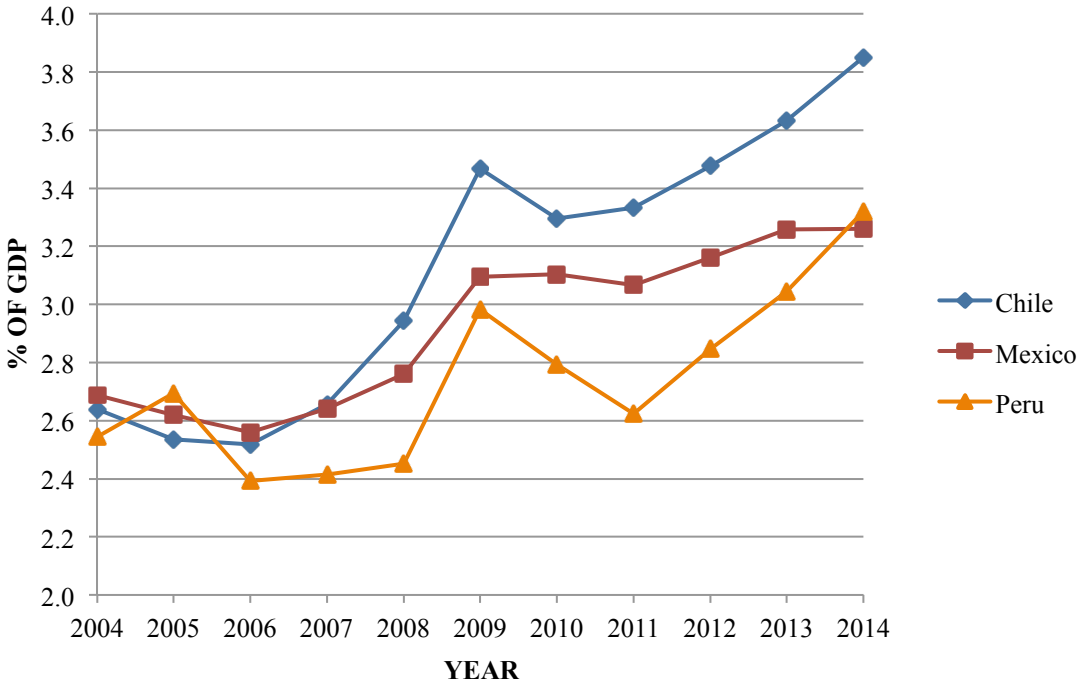
Table 3 Formal Coverage: Percent (%) of Population with Insurance

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

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

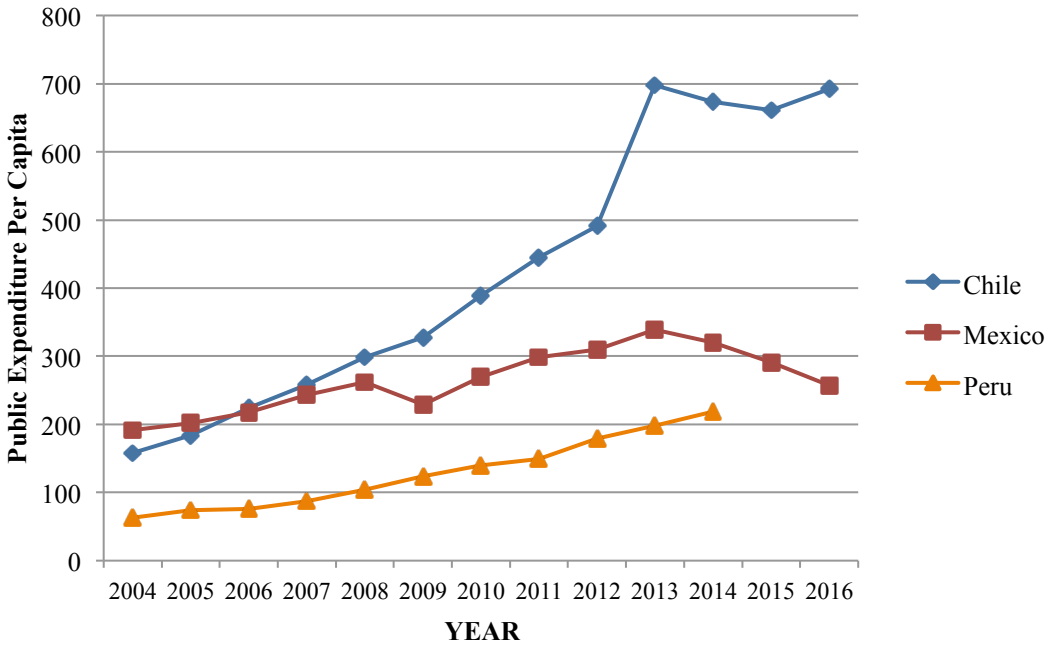
Another commonality we can observe is a general increase in state funding for health. However there are important differences. Figures 2 and 3 show that whereas the increase in funding for the health sector has been stable in Chile, the funding of the reforms in Mexico and Peru has not been constant.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

Figure 2 Funding for Health Reform: Public Health Expenditure (% of GDP)



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

Figure 3 Funding for Health Reform: Public Health Expenditure Per Capita (USD)



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

Chile

Following the schedule established in the law, in July 2005, AUGE began with 25 of the 56 planned diseases. The first AUGE decree, enacted in 2004, established the package of diseases and guarantees. The decree was to be updated every 3 years, keeping the same number of diseases or increasing them, based on their importance relative to the disease burden of the country, availability and cost of interventions, and availability of resources (Lenz 2007). AUGE also established the creation of an Advisory Board, formed by experts from outside the government (from health and economy), which would change every 3 years. Before updating the AUGE decree, the board revises a first proposal and advises MINSAL on its applicability.

The Treasury gave additional funding to MINSAL for the implementation of AUGE to enhance the resources of the public sector. Over a third of this funding was for the purchase of medicines (Lenz 2007). An important part of it was also to buy more equipment and hire more personnel in order to implement AUGE. Additionally, the AUGE Technical Secretariat had to work with health services across the country in order to make sure that attention for non-AUGE diseases would continue to work. Another important institution the reform introduced was the Health Superintendency. It is responsible for enforcing the fulfillment of guarantees by both FONASA and Isapres, and supervises the performance of both insurers and providers.

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

of services from the private sector. (See the appendix for a full description of the implementation process in Chile).

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

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

Mexico

For the implementation of SP to begin in January 2004, given the autonomy of the states, each one of the 31 state governors and the head of the Federal District had to sign "coordination agreements". By December 2003, 7 months after the approval of the law, no single governor had signed the agreement. The main reasons: 1) their reticence to provide the State Solidarity Contribution (ASE) and 2) the reduction of their ability to control the distribution of resources. The SP team managed to convince the state governors by emphasizing the transfer of fresh monetary resources and negotiating *how* the state governments could provide their ASE. They promised the governors that other things could count towards the ASE, and that they would only start contributing in cash in 2010.[17] Members of the team and Frenk himself affirmed that this was the only way to gain the allegiance of the governors.

As a SP team member noted, they did not foresee the reticence of state governors to contribute to SP during the legislative process. Moreover, the Director of the Economic Analysis Unit at the Health Secretariat noted: "*When the first [governors] that signed realized that they*

[17] Soccer fields, fountains, roads, and drains could count as "contributions".

could 'cheat on' the system, the others began to sign". These arrangements between federal and state governments regarding what would count as contribution and the independency of the local SP offices hurt the sustainability of the reform. One of the major hurdles the implementation of SP has faced is the lack of accountability of state governments. According to official SP data, most states only report 50% of the use of these resources; and some of them do not even report at all. (See the appendix for a full description of the implementation process in Mexico).

The number of families affiliated to SP saw rapid growth during Felipe Calderón's term (2006-2012), growing to over 43.5 million people by December 2010 (37% of the population). The budget assigned for the reform also grew. The fact that SP provided new resources to the health system in Mexico is undeniable. However, the Treasury introduced a reform to the SP bill in 2010 that changed the Social Contribution provided by the federal government.[18] All states, without exception, lost a significant amount of resources (Laurell 2013). According to official accounts, this was a necessary change since the states were affiliating the same individuals as part of different families. This has been highly contested as it is argued that the Treasury introduced this modification due to a lack of funds. This change, added to the fact that many states still do not contribute the whole amount of the ASE, has been one of the major problems faced by SP.

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

By providing financial protection to those from the uncovered population, SP could gradually close the gap between those who were part of the social security system and those outside it. Indeed, the differences in public spending per capita for social security members versus the SP population have reduced.[19] However, the limitations in terms of effective access to

[18] From 15% of a minimum salary in the Federal District (SMDF) assigned per family, to 3.92% of a SMDF assigned per individual.
[19] According to Flamand & Moreno (2014), the government spent 2.15 times more per capita for social security members in 2000 (before SP) and 1.5 in 2009 (after SP).

health attention of SP affiliates has not allowed for these two different segments of the population to come closer.

Peru

AUS passed a vote in Congress in March 2009. A special commission within MINSA, aided by the USAID funded project PRAES crafted AUS's National Implementation Plan in January 2009. The set of benefits and guarantees of health services that all health insurance institutions would be bound to fulfill (PEAS) considered 140 health conditions, for which timely and quality service had to be guaranteed.

When asked about how ambitious the package was, given the shortage of infrastructure and human resources in the public system, the PRAES member in charge of PEAS's design argued that infrastructure could be strengthened later and that "*to pose that a plan should exist after the [infrastructure] conditions exist delays the process.*" Indeed, MINSA began to implement AUS in some areas of Peru without the necessary infrastructure and human resources.

When the implementation of AUS started, 40% of the population (over 11 million people) was affiliated to SIS, the state's healthcare scheme for the poor.[20] With the introduction of AUS, more people affiliated to SIS, but before 2013 SIS's funding did not see significant changes. Lack of infrastructure and shortage of human resources got in the way, problems that could not be solved without a necessary injection of funding. The process of debate of AUS produced a law that lacked the necessary funding for implementation. During debate, plans to strengthen the infrastructure of hospitals and health centers, overcome the shortage of doctors, nurses and other health personnel never emerged. (See the appendix for a full description of the implementation process in Peru).

President Ollanta Humala (2011-2016) was the leader of the only party (PNP) that voted against AUS. In July 2012, Midori de Habich, former leader of the USAID funded projects, who had been actively involved in the agenda-setting and debate of AUS became health minister. MINSA started the implementation of AUS across the whole country.[21] One of the first steps was implementing a prospective type of payment for the services that SIS affiliates received. By the

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

[21] Some interviewees pointed out that de Habich convinced First Lady Nadine Heredia of the importance of continuing with AUS. Heredia was a powerful actor during Humala's government.

end of 2012, SIS was making trimestral monetary transfers to the hospitals and health centers before they provided services. An important injection of funding for the health sector arrived: whereas SIS's budget from 2008 to 2012 was between 400 and 500 million soles, it was 900 million (around 300 million USD) by 2013.

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

By 2016, over 54% of the population was affiliated to SIS, the government's free insurance scheme. While the number of affiliates grows, so do the complaints regarding the capacity of the public system to respond to this enormous demand. In theory, SIS could cover everything today, as they can also access a Complementary Plan to cover any other health intervention up to 2,600 USD and Extraordinary Coverage in case the cost for these extra interventions surpasses this sum. The former SIS Chief noted that they were spending a third of their budget on this and that was precisely why they "*did not want them [the affiliates] to know.*" 40% of SIS affiliates are in rural areas of Peru, precisely where access is more limited. When the required technology or personnel is not available in a facility, patients can be referred to the nearest facility able to cover the need. In the majority of cases, these patients do not go to the referred facility (by 2016, only 0.5% of referred patients accessed the required care). The main reason is that patients cannot afford transport to a different facility.

AUS brought the possibility of increasing SIS's funding, which more than doubled between 2012 and 2014. The main concern of MINSA officials is the stability of the funding that they have received in the past three years. MEF reduced SIS's budget for 2016 by almost 3% and by 15% for 2017. There is uncertainty with regards to how much money MEF will give year by year. Many experts concur that the best way to give stability to the funding assigned to AUS is to calculate a premium that could become the base for the assignment of funding, then funding would increase as the number of affiliates increases.[22]

[22] This is hard because there is a lot of filtration in the system, which MINSA has not addressed as they can say that they are the biggest insurance institution in the country.

Alternative Explanations

I have shown the importance of whether the core values of political parties relate to the issue of reform (programmatic commitments). This defines qualities of the policy and its implementation. The presence of strong left-wing parties in government cannot alone explain the introduction of reforms into the agenda nor the passage of reforms. Under right-wing parties, we can also see these reforms being introduced and approved. The analysis provided shows the importance of paying more attention to these cases. The ideology of the party or coalition in government does make a difference in terms of the direction they will push the reform towards, as left-wing parties will aim for a more universal type of reform and further restrictions to the private sector than right-wing parties. We will expect the same from left-wing parties in opposition. Regardless of party ideology, however, if the parties lack core values around which their leaders cohere or if such values do not relate to the policy issue, the quality of the legislation regarding funding and infrastructure will suffer.

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

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

Regarding the presence of diffusion across cases, although there was knowledge of the reforms taking place in other countries, there is no evidence of a policy model spreading across countries. The policymakers involved in the three cases of reform were aware of similar efforts towards universalization abroad, but they did not attempt to copy content. Whereas we may allow that the recognition of a need for reform was related to a diffusion effect, there was no adoption of the content of other models. The role that USAID in Peru and Funsalud in Mexico had in setting the issue into the agenda is a form of diffusion, which comes through an international network of technocrats. These technocrats were pushing for some form of expansion of healthcare. However, they did not copy the content of the bills from country to country. Political parties gave these networks the space to direct the processes of reform, given the parties' lack of commitment to the reforms.

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

Conclusion

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

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

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

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

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Two Paths to Reform: Political Parties and Technocrats in Latin American Healthcare Policy

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Appendix

Agenda-setting: Chile

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

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

Bachelet did not publicly declare her opposition to AUGE, while seeking to block it behind the scene. Sandoval noted that for Lagos and the commission it was clear that the problem of inequity in the system "*could not just be solved with more funding*" but it was necessary "*to grant rights and access mechanisms to these rights.*" Health Minister Bachelet blocked the progress of the bill. An ally of Bachelet was the Chilean Medical College that also opposed the idea of prioritization and rather supported giving more funding to the public sector.[1] There was a difference in strategies for the reform between Bachelet and the reform commission, which led to a conflict known to all participants of the reform process. In this way, the different members of

[1] Bachelet organized working groups with the Medical College representatives in 2001, without any coordination with the commission.

the coalition shared the same goal, to improve an unequal system, but they did not agree on the means to that end.

In January 2002, Sandoval, fed up with Bachelet's obstruction, submitted his written resignation to Lagos, but the president did not accept it and decided to instead appoint a new health minister and name Bachelet as minister of defense. The new minister Osvaldo Artaza (PDC) had one command: to send to and achieve the approval of AUGE in Parliament. Following this, some members of the commission became part of MINSAL.

Agenda-setting: Mexico

The Health Secretariat's Strategic Planning Office crafted the first draft of the program, which emphasized the need to switch from a supply subsidy type of system to a demand subsidy system and to advance towards an integrated public system. During 2001, the coordination continued to develop the details of the reform and eventually gave it the name *Seguro Popular*.

The secretariat carried out a SP pilot before sending the bill to Congress; its implementation began in 2001. They selected five states for the pilot (Aguascalientes, Campeche, Colima, Tabasco, and Jalisco), based on the fact that they were relatively small, had some infrastructure, an important segment of uncovered population (but not unmanageable), and the disposition of the State Health Secretariats to collaborate. Further, as then head of the Financial Protection Direction Héctor Hernández noted, it was also important to go "*where they could make allies for the future debate of the bill*". Only 2 of the 5 states were PAN (Aguascalientes and Jalisco), whereas the remaining 3 were PRI. The goal was to have as many families under SP as possible in each one of the pilot states before Congress started to debate the reform.

Agenda-setting: Peru

A key actor during the agenda-setting of the Peruvian health reform was Partners for Health Reformplus (PHR*plus*), a five-year project (2000-2005) funded by the United States Agency for International Development (USAID) in Peru. In 2005, they convened representatives on the issue of health from all parties. At the end, they produced the "Agreement of Political Parties on Health", and the continuation project of PHR*plus*, Promoting Alliances and Strategies (PRAES), presented it to the public in January 2006. One of the main foci of the meetings was the promotion of a policy of universal health insurance (AUS) via a fragmented system, and so it was listed as a key priority in the agreement. Nearly all the party representatives that participated

in the meetings signed the agreement, with the exception of the left-wing UPP. According to its representative, it did not sign because AUS "*saw health as a commodity and not as a right.*"

Motivated by the discussions fostered by PHR*plus* and PRAES, between December 2006 and April 2007, different parties introduced bills to Congress.[2] These bills did not have their origins in debates within the parties. One of them came from the right-wing coalition UN. UN had two main advisors on health during that time: Jorge Ruiz, who was also CEO of an important private clinic in Lima, as well as a board member of the Private Clinics Association of Peru (2002-2012), and Alberto Valenzuela, who was also the technical director of the Private Clinics Association of Peru. Both advisors noted that in 2005 they "*discussed some ideas with*" PRAES' leader at the moment, Midori de Habich (who then became health minister). De Habich stated that "*it is possible that PRAES had put together a draft of AUS and shared it with all the participants*" as it was a rule of the group to not help a specific party. A month later, APRA introduced a second bill, which was very similar to UN's. The main APRA advisor on health issues claimed that it was due to a dialogue that existed with the UN advisor Alberto Valenzuela, who became "*a great technical and political support*".

The opposition, the UPP-PNP coalition, also introduced bills on the issue. First, they proposed a universal social security system that would put an end to the fragmented system. However, just a couple of months later, they "*jumped into the AUS boat*" (in the words of the main health advisor of the coalition) as they understood their original idea of a universal public insurance was not going to get anywhere. Then president of the Health Committee (HC) in Congress, Luis Wilson (APRA), formed a working group on AUS in July 2008. The health advisors of the different parties participated, as well as PRAES members Aníbal Velásquez (who also became health minister) and Ugarte.

Within USAID, AUS was regarded as a major success as they decided important details of the reform. They successfully prevented the universalization of the social security system and instead pushed for the continuation of a fragmented system.

[2] In Peru, political parties as well as individual legislators can send bills to Congress. A political party can send a bill indicating that it is being sent at the initiative of a specific legislator.

Debate: Chile

In the Chamber of Deputies, the Health Committee (HC) held 18 hearings between June and November of 2002. After intense discussion, AUGE reached floor debate in December of that year. Whereas support for a health reform was widespread within Concertación, there was not widespread support for the strategy that President Lagos had for the reform. Members of the so-called "medical block" in the Chamber, formed by Concertación members who were also doctors opposed some specifications of AUGE. A first point of disagreement was the inclusion of the private sector. For the block, this would only serve to strengthen the private sector.

A second point of disagreement was the prioritization of diseases, which the medical block considered discriminatory against those patients with non-AUGE diseases. Soledad Barría (PS), who was at MINSAL during Bachelet's term as heath minister noted that "*[the idea of granting] enforceable rights itself was good, but they could not stop to take care of what was not AUGE.*" This split did not represent a programmatic division. Although there was division regarding the strategy of reform for the Chilean health system, there was programmatic agreement on the need for a reform that would increase access to health for people and bring more equity to the system.[3]

The AUGE team decided to implement pilots within FONASA. The pilots began in August 2002, with 3 of the 56 health interventions that AUGE would guarantee. The pilots generated civil and political support. Moreover, as then chief of the AUGE Technical Secretariat noted, the pilots were important "*to ensure the commitment of the Treasury*". For then FONASA official Ghilaine Arcil (who became chief of the AUGE Technical Secretariat), the pilots were also helpful to gain implementation expertise.

Isapres Association's Executive Director Rafael Caviedes noted that they agreed with having health priorities. Then Research Manager Gonzalo Simon also noted, "*the coverage of Isapres affiliates was much higher than that provided by the public sector, therefore they had no problem with AUGE.*" However, they strongly opposed the Solidarity Fund (SF). The private insurance sector was, indeed, at great risk. Their premiums would have gone up to compensate for the 3% taken through the SF. Therefore, their affiliates with fewer resources would have moved to FONASA. For both Caviedes and Simon the SF was like imposing a specific tax on

[3] This was not a PS-PPD versus PDC division, but it cut across parties. Indeed, Senator Antonio Viera-Gallo (PS) and FONASA Director Alvaro Erazo (PS) supported AUGE, whereas Senator Mariano Ruiz-Esquide (PDC) sided with the medical block. In the words of then Health Vice-minister Antonio Infante, "*Lagos' strong presidential figure*" was determinant in settling these differences.

those affiliated to a private insurance. According to them, people should not have to contribute to a system (public) that they will never use.

With a majority in the Chamber of Deputies, Concertación was able to pass AUGE on the floor in January 2003, even though Alianza voted against the articles regarding the SF. The Senate then received the AUGE bill. Alianza Senators Espina and Matthei abstained from voting for the SF articles in the HC at the Senate, but they were still approved with Concertación votes. During floor debate, Senator Ruiz-Esquide (PDC) explained that through the political agreement reached between Alianza and Concertación, they decided to eliminate the SF. Finally, the bill returned to the floor in the Chamber of Deputies, which approved AUGE with 105 votes in favor, 1 against (Accorsi, PPD), and 1 abstention (Girardi, PPD).[4]

Debate: Mexico

The joint Health and Social Security and Finance committees in the Senate approved a draft on April 23rd 2003. Health Secretary Julio Frenk and his team had managed to gather a lot of support from state governments before sending the SP proposal to the Senate. In the words of Frenk's Coordinator of Advisors Miguel Lezana: "*Most governors, when they saw that with the reform they were going to get more money, they bought it.*" PRD governors were not the exception: Ricardo Monreal, Governor of Zacatecas became one of the main advocates of SP. Then Nuevo León Governor Zacarías Villarreal (PRI) noted: "*We did the lobbying with our federal deputies and senators… Every state had their fingers crossed for SP to be approved*."

On April 29th, the Chamber of Deputies approved the bill with 305 votes in favor (a third came from PRI). A day later, the Senate approved the bill with 88 votes in favor and 6 against (from PRD).

Whereas the role of the private sector was highly relevant during the legislative process of the Chilean reform through the influence of right-wing parties, in Mexico it was not very salient. As was the case in Chile and Peru, the private provision sector knew it could benefit, as the public sector would be unable to respond to the new demand for services.[5] Without any public display of their support, they were connected to the policymaking process of SP through

[4] Accorsi noted that he did not regret his vote, but that he was content that AUGE passed because "*it was a tie between strengthening the public system and integrating with the private system*" and it has been beneficial to Chileans.

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

Funsalud, the organization that gave birth to the core ideas of the reform. Key actors from the private sector were part of Funsalud's board of directors.

Debate: Peru

The opposition to AUS mainly centered on the role of the private sector. Some legislators claimed that the reform was going to privatize the health system by bringing more business to the private sector. The private sector would indeed see itself being highly benefited by AUS through the sale of health services to the public sector. The Private Clinics Association of Peru did not send a representative to the HC meetings neither did they send a formal opinion to the committee. They already had two of their members as key actors in the process since its origins: Ruiz, board member of the association and CEO of one of the most important clinics in Lima, as well as Valenzuela, technical director of the association, who were also UN advisors.[6]

Exactly six days after the HC in Congress gave its opinion, the Executive sent a bill to Congress. It was nearly identical to the HC's opinion. According to then Health Minister Ugarte, this bill was made in dialogue with some legislators' advisors as well as with PRAES leader Midori de Habich. The president of the HC, Wilson, noted that it was important that the Executive sent this bill to show its political support to the project. The law passed with 59 votes in favor; 14 of those votes came from left-wing party UPP, one of the parties that had opposed AUS since the beginning.

The process of debate of AUS was not very open. For UN Congressman Menchola, member of the HC, "*the script was already written, there was not much to conciliate.*" There was a very limited group of people participating in the policymaking process of AUS, who rotated between MINSA, the USAID funded projects, and the private sector. The evidence shows that there was no real commitment to make the debate process a participatory one. An excerpt of my conversation with the main HC advisor at that time might be indicative of the process: "*I have to admit that I was a little bit of a dictator… 'Do you like it [a part of the AUS bill]? No? I will include it anyways.' Otherwise, it did not move forward.*"

[6] In a press interview a couple of months before the law was approved, Ruiz affirmed: "*From the side of the providers, a market opens, an opportunity... The gap between the public offer of services and insurance coverage has to be closed by a public-private partnership. AUS is an opportunity for private enterprise*."

Implementation: Chile

President Bachelet (2006-2010) named Soledad Barría as her first health minister, who had been one of the main opponents to the prioritization that AUGE entailed.[7]

Something that the AUGE reformers did not plan for was the need for more specialists in the public sector. Neither during the end of President Lagos' term nor during President Bachelet's was there a plan to train more specialists. The main consequence of this is that waiting lists, although small for AUGE diseases (in comparison to the rest), still remain.

In the private sector, the implementation of AUGE went smoothly, as they were able to construct the networks of providers for AUGE patients without problems. Representatives of the Isapres Association noted that they thought AUGE would not have much of an effect in the sector, as people would prefer to continue being treated by the doctors they already knew instead of having to change by entering a network. Nevertheless, the use of AUGE by Isapres affiliates has been increasing. Patients often decide to get attention through AUGE for diseases that require a large quantity of medicines.[8]

President Piñera's (RN) administration (2010-2014) introduced the Bono AUGE, a mechanism that would allow patients on AUGE waiting lists to get attention through private providers.[9] The association of private clinics, Clínicas de Chile, was an important participant in the design of this mechanism. General Manager Ana Albornoz noted that the idea came from her association and they put it on the table before the 2009 presidential election. Albornoz recalled that they "*imagined that there would be an avalanche of patients to the private sector.*" An increase in the flow of new patients only began with the addition of Bono AUGE.

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

[7] Barría noted that what she and other Concertación members were worried about was the privatization of health and the possibility of discrimination against people with non-AUGE diseases, but that they did not disapprove of the reform since AUGE "*allows you to plan based on the demand [for attention] and people's health needs*."
[8] Chemotherapy is far less expensive through AUGE, so nearly 100% of Isapres affiliates with cancer use AUGE.
[9] The co-payments vary depending on the provider the patient chooses and it is completely free for groups A and B of FONASA.

reform of the private system to Parliament. Whereas nearly 21% of the population was affiliated to Isapres in 2000, only 14.5% was by 2014. Regarding private provision, private clinics provide 45% of all the health services in the country, delivering attention to around 8 million Chileans (nearly half of the population).

Implementation: Mexico

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

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

The REPSS are not transparent regarding the use of resources for the purchase of medicines and services. In 2015, the Treasury introduced different measures to reduce the autonomy of the states and bring more efficiency to the use of resources.

By 2016, 46% of the population was affiliated to SP, 41% to the social security, 6% had a private insurance, and the remaining 7% was still unprotected. The Mexican Association of Insurance Institutions (AMIS) has been working on proposals about how to complement SP with private coverage since the passage of the bill. AMIS Director Dolores Armenta noted that they saw this area of opportunity and "*have been working hard on lobbying for it*."

The purchase of private services for SP interventions has not seen a lot of progress. The states prefer to buy from their own public clinics and are reticent to buy private services. As noted by the General Director of Centro Médico ABC, one of the most important private

providers in the country, the sector is interested in selling to SP in order to use their idle installed capacity, but what SP pays is not enough to even cover the cost of production.

Implementation: Peru

The Implementation Plan established that AUS would start in 7 strategic areas (pilots, which had between 54% and 84% poverty) in December 2009, guaranteeing treatment for 34 health conditions. Another USAID funded project called HS2020 was in charge of the implementation in these pilots. President García's term ended in 2011 with a mediocre implementation of AUS in the pilot regions.

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

Three main decrees attempted to tackle the shortage of human resources and infrastructure of MINSA facilities. One decree tried to make the wages of doctors homogeneous across the country, as well as giving an incentive to doctors that had to work in remote and border areas through a bonus system. Another decree endeavored to make the investment in infrastructure a more expedited process, together with the project of building 11 new national hospitals, 23 regional and 170 provincial. A third decree proposed the exchange of services between SIS and EsSalud as well as purchasing services from the private sector. Some exchange of services between SIS and EsSalud has started to take place; however, the main problem is that the payment of those services has been slow.

The main problem with hiring private services has been that some services are overvalued, in which case SIS ends up paying more for a service in a private clinic than a private insurer would pay. Another problem is the lack of regulations for emergency care of SIS affiliates in private clinics.[10] The sustainability of this process is also a concern. If the purchase of private services was posed in order to decongest the public sector because its offer was insufficient, the question is until when and to what extent will they continue to acquire private services.

[10] See Arrieta 2012 on over-diagnosis of SIS affiliates.

Another group of decrees attempted to improve the governance of the health system. One of them increased the authority of SUNASA, the entity in charge of monitoring the implementation of AUS. In June 2014, SUNASA became SUSALUD and the role of the institution expanded; it would not only protect the rights of insured people, but of all users of health services by monitoring health facilities and insurance entities (both public and private). Moreover, their funding increased from 17 million soles in 2013 to 27 million in 2014 and 52 million in 2015. They have two offices in Lima and one in a province.