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**The Political Dimension of Health Reform:  
The Case of Mexico and Colombia**

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**Dedication**

**Para el Señor Islas**

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## **Abstract**

This thesis analyses the state's capacity to pursue health reform. It argues that the feasibility of health reforms, as well as their final content, are in great part determined by their political context, and the political strategies reformers resort to when pursuing their policy agenda. The analysis is framed in the political context in which a reform initiative evolves, the political dynamics of and around the health reform process, and the characteristics and strategies of the teams in charge of leading policy change (change teams). The research aims to contribute to existing knowledge in the health policy field by furthering the analysis and explanation of the political feasibility of health reforms.

A two case study comparative analysis is used based on primary and secondary sources and in-country interviewing. Colombia and Mexico, challenged by the need to attain universal coverage, and faced with large inefficiencies, set about to transform their health systems in the 1990's. While Colombia was successful in passing legislation and initiating implementation, Mexico made a series of similar attempts, but its reform was brought to a near halt. The analysis of these contrasting outcomes given the similar choice of political strategies in comparable political contexts, allows for a greater understanding of the factors at play.

Key findings demonstrate the relevance of the political context in determining the potential of interested actors within and outside the state, to influence health reforms. The study also reveals the remarkable resemblance between the political strategies used by health reform teams, and those used by economic adjustment teams in the 1980's. While these strategies enabled the latter to introduce major policy change, they helped health reform teams only partially. As a result, health reformers were successful in enabling the creation of new private health financing and provider organisations, but the transformation of the old public health service institutions remains a challenge.

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## Acronyms for Colombia

Acronym	Spanish	English
ACEMI	Asociación Colombiana de Medicina Prepagada	Association of Pre-paid Medicine Organisations
AD-M19	Alianza Democrática M-19	Democratic Alliance M-19
Affiliate	La persona que se afilia a la entidad promotora de salud	A person who pays a premium to enrol in an EPS
ANC	Asamblea Nacional Constituyente	National Constituent Assembly
ANDI	Asociación Nacional de Industriales	National Industry Association
ANIF	Asociación Nacional de Instituciones Financieras	Financial Institutions National Association
ARS	Administradora Régimen Subsidiado	Subsidised Health Plan Management Organisation #
ASCOFAME	Asociación Colombiana de Facultades de Medicina	Colombian Medical School Association
ASMEDAS	Asociación Médica Colombiana	Colombian Medical Association
ASOBANCARIA	Asociación Bancaria	Banks Association
AVISA	“Años de Vida Saludables”	Disability-Adjusted Life Years (DALYs)
CAJANAL	Caja Nacional de Previsión	National Prevision Institute
CCF	Caja de Compensación Familiar	Health Co-operative Organisation
CNSSS	Consejo Nacional de Seguridad Social en Salud	National Council for Social Security in Health
CONPES	Consejo Nacional de Política Económica y Social	National Council on Social and Economic Policy
CONSENSO	Consenso	Consensus (think tank)
CUT	Central Unitaria de Trabajadores	Workers Unitary Union



DNP	Departamento Nacional de Planeación	National Planning Department
ECOPETROL	Empresa Colombiana de Petróleo	Colombian Oil Enterprise
ECV	Encuesta de Calidad de Vida	Quality of Life Survey
ELN	Ejército de Liberación Nacional	National Army for Liberation
Enrolee	Persona cubierta por una EPS: el afiliado o sus familiares	Person covered by an EPS: affiliate or his / her family members
EPS	Entidad Promotora de Salud	Health Service Provider for the Regular Health Plan
ESE	Empresas Sociales del Estado	Health Service Provider Institution for State Employees
ESS	Empresas Solidarias de Salud	Health Service Provider for the Subsidised Health Plan Health
FARC	Fuerzas Armadas Revolucionarias de Colombia	Colombian Revolutionary Armed Forces
FASECOLDA	Federación de Aseguradores Colombianos	Colombian Insurers Federation
FEDESARROLLO	Fundación para la Educación Superior y el Desarrollo	Higher Education and Development Foundation
FENALCO	Federación Nacional de Comerciantes	National Traders Federation
FES	Fundación para la Educación Superior	Higher Education Foundation
FECODE	Federación Colombiana de Educadores	Colombian Teachers Federation
FESCOL	Fundación Friedrich Ebert de Colombia	Colombian Friedrich Ebert Foundation
FOSYGA	Fondo de Solidaridad y Garantía	Solidarity Fund
FRB	Fundación Restrepo Barco	Restrepo Barco Foundation
ICBF	Instituto Colombiano de Bienestar Familiar	Colombian Institute of Family Welfare
IDB	Banco Interamericano de Desarrollo	Inter-American Development Bank
IPS	Instituciones Prestadoras de Servicios	Health Service Provider Institutions

ISS	Instituto de Seguros Sociales	Institute of Social Security
IVA	Impuesto de Valor Agregado	Value Added Tax –VAT
M-19	Movimiento Revolucionario 19 de Abril	Revolutionary Movement April 19
MOH	Ministerio de Salud	Ministry of Health
MSN	Movimiento de Salvación Nacional	National Salvation Movement
NGO	Organizacion no Gubernamental	Non-governmental Organisation
POS	Plan Obligatorio de Salud	Mandatory Health Plan
POS-S	Plan Obligatorio de Salud Subsidiado	Mandatory Subsidised Health Plan
PRT	Partido Revolucionario de los Trabajadores	Workers Revolutionary Party
RAP	Prima con Ajuste de Riesgo	Risk Adjustment Premium
SINTRA-ISS	Sindicato de Trabajadores del ISS	ISS Workers Union
SISBEN	Sistema de Identificación de Beneficiarios de los Subsidios del Estado	Identification System of Government Subsidy Beneficiaries
SOAT	Tarifas para el Seguro de Accidentes de Tránsito	Tariff schedule of fee-for-service reimbursement for medical procedures
UP	Unión Patriótica	Patriotic Union; FARC political movement
UPC	Unidad de Pago por Capitación	Risk Adjusted per capita Payment
USO	Union Sindical Obrera	Workmen Union
WB	Banco Mundial	World Bank

## Acronyms - Mexico

Acronym	Spanish	English Translation
AMGD	Áreas Médicas de Gestión Desconcentrada	Decentralised Medical Areas
DALYS	Años de Vida Saludable (AVISA)	Daily Adjusted Life Years
DRGs	Grupos relacionados por diagnóstico	Diagnostic-related groups
IVCM	Seguro de Invalidez, Vejez, Cesantía en Edad Avanzada y Muerte	Pensions Insurance
MIAIS	Modelo Institucional de Atención Integral de la Salud	Institutional Model for Comprehensive Health Services
PRONASOL ( <i>Solidaridad</i> )	Programa Nacional de Solidaridad	National Solidarity Program
PRSS	Programa de Reforma del Sector Salud	Health Sector Reform Program
SAR	Sistema de Ahorro para el Retiro	Retirement Savings System
SCNS	Sistema Nacional de Cuentas de Salud	National Health Accounts System
SEM	Seguro de Enfermedades y Maternidad	Illness and Maternity Insurance
SINDAS	Sistema de Incentivos al Desempeño en Áreas de Salud	Performance Incentives System for Health Care personnel.
SNCS	Sistema Nacional de Cuentas de Salud	National Health Accounts System
SSF	Seguro de Salud para la Familia	Family Health Insurance
ABM	Asociación de Banqueros de México	Mexico's Bankers Association
AFORE	Administradora de Fondos para el Retiro	Pension Funds Administrator

AMIS	Asociación Mexicana de Instituciones de Seguros	Mexican Association of Insurance Institutions
CANACINTRA	Cámara Nacional de la Industria de la Transformación	National Chamber of Transformation Industry
CCE	Consejo Coordinador Empresarial	Business Co-ordinating Council
CEDESS	Centro de Desarrollo Estratégico para la Seguridad Social	Strategic Development Centre for Social Security
CNC	Confederación Nacional Campesina	National Peasant Confederation
CNSF	Comisión Nacional de Seguros y Fianzas	National Commission of Insurance and Bail Bonds.
CNOP	Confederación Nacional de Organizaciones Populares	National Confederation of Popular Organisations
CONAPO	Consejo Nacional de Población	National Population Council
CONCAMIN	Confederación de Cámaras Industriales	Confederation of Industrial Chambers
CONCANACO	Confederación de Cámaras Nacionales de Comercio	Confederation of National Commerce Chambers
CONSAR	Comisión Nacional del Sistema de Ahorro para el retiro	National Committee for the Retirement Savings System
COPARMEX	Confederación Patronal de la República Mexicana	Mexican Republic Employers Confederation
CT	Congreso del Trabajo	Workers Congress
CTM	Confederación de Trabajadores de México	Mexico's Workers Confederation
FSTSE	Federación de Sindicatos de Trabajadores al Servicio del Estado	Federation of State Workers Unions
FUNSALUD	Fundación Mexicana para la Salud	Mexican Health Foundation
IMSS	Instituto Mexicano del Seguro Social	Mexican Institute for Social Security

ISES	Instituciones de Seguros en Salud	Health Insurance Administrators (HMO's)
INSP	Instituto Nacional de Salud Pública	National Institute of Public Health
ISSSTE	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado	State Workers' Social Security and Services Institute
ITAM	Instituto Tecnológico Autónomo de México	Mexican Technological Autonomous Institute
PAN	Partido Acción Nacional	National Action Party
PRD	Partido de la Revolución Democrática	Democratic Revolution Party
PRI	Partido Revolucionario Institucional	Institutional Revolutionary Party
PT	Partido del Trabajo	Labour Party
SECOFI	Secretaría de Comercio y Fomento Industrial	Commerce Ministry
SNTSS	Sindicato Nacional de Trabajadores del Seguro Social	National Union of Social Security Workers
SPP	Secretaría de Programación y Presupuesto	Planning Ministry
SSA	Secretaría de Salubridad y Asistencia	Health Ministry
SSPEMEX	Servicios de Salud de PEMEX	Health Services for Oil Workers
SSSD	Servicios de Seguridad y Salud del Ejército	Health Services of the Army
SSSM	Servicios de Seguridad y Salud de la Marina	Health Services for the Navy
STPS	Secretaría del Trabajo y Previsión Social	Labour Ministry
UNAM	Universidad Nacional Autónoma de México	Mexico's National Autonomous University
UNT	Unión Nacional de Trabajadores	National Workers' Union

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**PART I**

**The Political Dimension of Health Reform**

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## **Chapter 1. Introduction**

During the last two decades, most of the countries in the Latin American region have embarked on a period of state reform that has included the social, political and economic spheres. The role of the state, as well as that of markets has been reassessed and, as a result, there have been significant changes in almost every aspect of public policy. While the first areas that called the attention of policy-makers were located within the economic sphere – monetary policy, fiscal policy, trade liberalisation, and the deregulation of domestic markets, among others – the social sector was to follow with particular emphasis on the education and health sectors<sup>1</sup>.

In the health sector, most countries faced the need to transform their large and highly inefficient health systems which had been operating along the same policy lines for fifty years since the early post-war period. Even though this scenario was not born of an imminent crisis, the inefficient service delivery, spiralling costs, and increased demand for health services – due to society's epidemiological and demographic transitions – were generating deficits in the State's public finances, making these policy changes urgent. While in most countries there had been important advances in the health status of the population, persistent coverage gaps, inefficiencies in service organisation and provision, deteriorating quality, and severe financial constraints called for the need to reform the health systems.

In the face of these policy challenges, there was increasing consensus about the need for structural change in the health sector. However, there was no similar understanding on the content of a health reform agenda. The definition of the problems to be solved, the means to solve them, as well as the speed and scope of policy change were all contentious issues, as they each affected the interests of different groups and individuals.

Health reform formulation and implementation means changing “how resources are allocated within the health sector, how the financial burden is shared across population groups and ultimately, who gets what kind of services” (La Forgia,

1994:2). It is therefore a highly political process, mobilising many groups within the state and in society, whose interests may be affected by the envisioned policy changes. As a result, the political dimension of health policy formulation and implementation has come to the foreground in recent times as it has proven to be a key factor in determining the feasibility of health policy change as well as its impact on the health status of the population.

Reform implies both institutional change and adjustments in the distribution of health resources and services, and these reflect new dynamics in state-society relations. Interest groups in society compete for health resources and services with different views and expectations about the role of the state, as well as their entitlements in access to public services and resources.

However, it would be misleading to consider that the state formulates its policy solely by reacting to these social demands. The state plays an active role in initiating the reform process and determining its policy content. But the state is not a monolithic actor with a single policy preference. Different groups of policy-makers may have contending views about the goals and means of a health reform, and ultimately, about the role the state is to play.

This complex process draws interest groups from both society and the state into the political struggle that permeates health policy redefinition. These groups will try to influence the decisions of the group of policy-makers who are in charge of formulating and implementing the health reform – the change team<sup>2</sup>.

This thesis analyses the converging point where state and society meet in the process of health reform by looking into the characteristics and the dynamics of these groups of policy-makers in charge of bringing about policy change. It does so by looking at the experience of these teams in Mexico and Colombia in promoting significant changes in the institutional configuration of their health care systems, the role of the state and of the private sector, and the nature of the services made available to the population.



As it will be described in the following chapters, health reform initiatives in Colombia (1990 – 1994) and Mexico (1995 – 1999), were among the 16 countries in the region which embarked on a reform of their health systems (Cruz-Saco and Mesa-Lago, 1998). These initiatives are representative of the efforts in the region to face the challenge of transforming the public provision of health services. Their health care systems share similar structural problems that, along with restricted public expenditure, have rendered the state – and society as a whole – incapable of solving the serious equity, efficiency and quality problems that each country faces. In both cases, this process has meant a serious reconsideration of the roles the state and society play in ensuring each citizen access to health care.

Access to health care in these countries is highly stratified along socio-economic lines, health care resources are concentrated in large cities, where there is duplication of infrastructure and service provision, as well as overlapping financial arrangements for users. At the same time, marginal rural areas still have little access to basic health care, and users face erratic or non-existent referral to other levels of care. The very poor face serious geographic and economic barriers to quality care.

As the case studies will show, Colombia and Mexico had similarities in their reform agendas, but their objectives varied, influenced by the context in which they were implemented, and the characteristics of the policy-makers who led the initiatives. Having said that, both faced similar obstacles, and resorted to very similar political strategies to try to overcome them. This thesis analyses the strategies that were formulated in response to the political opportunities and limitations present in each country for the political feasibility of pursuing health reform.

The research concentrates in the first instance on the creation and use of change teams as a strategy to pursue health reforms in the light of the political challenges presented by the context in which the policy changes were to take place. For this purpose, and in order to enhance the strength of its comparative analysis, an aspect of the reforms that was similar in both cases was selected and its process

analysed through the same variables. This particular aspect had to do with opening the possibility for the private sector to participate in the provision of health care and the management of health care funds previously under the exclusive responsibility of government agencies – MOH and/or social security institutes.

The thesis contends that while the importance of the challenging complexities behind a policy change of this nature are not to be underestimated, the main factor determining the degree of accomplishment of these reforms is political in nature, and thus has to do with the interplay of the different actors involved, their strategies and potential to influence the process, and the strategies used by reformers to pursue their reform agenda.

The objectives of this thesis are twofold in that it aims to contribute to the scholarly debate on the politics of health reform (analytical objectives), and, at the same time, it intends to support ongoing health policy decision-making (policy relevant objectives). Thus the objectives of this thesis can be summarised as follows:

**General analytical objectives:**

- To understand the political factors intervening in the state's capacity to promote health reform.
- To analyse the characteristics and strategic decision-making of state actors involved in health reform.

**Policy relevant objectives:**

- To elaborate an analytical framework that may help to expedite the analysis and understanding of the political context of a country pursuing health reform.

- To use this framework to help identify the moments and places in the health reform process where its political feasibility is at stake.
- To use this framework to help identify and assess the strategy options reformers face in view of the political context in which they are pursuing health reform.

In analysing the political dimension of health reforms this thesis aims to contribute to ongoing health reform efforts whose leaders, in spite of the differences in their policy agendas, are facing similar political challenges and having to make similar decisions.

The thesis is divided in four parts. Part 1 presents a critical literature review of the current knowledge and research in the field, the analytical framework that is used, and the research methods. Part 2 presents the Colombia case study. Part 3 presents the Mexico case study and Part 4 presents the discussion and conclusions resulting from the comparative analysis of the two case studies.

## **1.1 Review of Current Knowledge and Research**

### **1.1.1 Health Reforms**

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

However, there is no consensus on a definition for health reform and what it entails, and it has been argued that there is a wide variety of policy mixes that are being denoted as *health reforms* referring “in a very loose way to a package of policy measures affecting the organisation, funding and management of health systems”(Zwi and Mills, 1995:314). But although they have varied in content and scope, health reforms share common general features in that most involve changes in the institutional configuration of the health care system, in the role of the public and the private sector, and ultimately, in the nature and amount of services accessible to different groups of the population (La Forgia, 1994; Berman et al., 1995).

The OECD notices a shift in the objectives sought through policy change and reform in industrial countries. While previously there was an emphasis on expanding coverage and the range of services with a rather stable amount of resources, now, with the underlying concern about cost containment, the thrust of reforms is how to provide the necessary access at reduced costs (OECD, 1996). Following this trend, health sector reform proposals have tended to emphasise the need to “control costs, make systems more responsive to patient interests, to assure quality of care, and to provide incentives to raise productivity and effectiveness of treatment” (La Forgia, 1993:7) and seek market mechanisms as a means to attain these objectives (World Bank, 1993).

According to Zwi and Mills (1995) all these factors stem from a change in policy paradigms that emphasises the epidemiologist and economic perspective and a stronger appreciation of market forces. They point to the fact that this new trend emerges as a reaction to the failures of the previous state model, and is not based on policies with proven effectiveness. Indeed, there is an ongoing debate as to whether market mechanisms can attain the goals of improving quality, efficiency and equity (Gilson and Mills, 1993; Collins et al., 1993) and whether middle and low-income countries have the state capacity to resort to such mechanisms with any possibility of success (La Forgia, 1993). Hisao also remains very critical of the “effectiveness of using free market principles to structure the health sector” (Hsiao, 1995:161) and warns about the fact that many countries have defined and

undertaken health reforms “often not informed by facts, but driven by ideology” (Hsiao, 1995:162).

As part of, or reflecting upon structural adjustment programs, health sector reforms in less developed countries are seeking to diminish public intervention, redistribute the financial responsibilities for health care and introduce market mechanisms (Walt and Gilson, 1995). Ugalde and Jackson (1995) have also noted that due to international influence on country-level policy definition, there is a striking resemblance among health reform packages across very dissimilar contexts. These include the separation of financing and provision of health services, the introduction of cost-effectiveness analysis to establish policy priorities and resource allocation, the introduction of user fees and expansion of compulsory insurance, and the increase in the private sector’s role in areas that were previously considered the exclusive jurisdiction of the state (Zwi and Mills, 1995).

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

In the two cases that are analysed in this thesis, reformers considered the creation of new providers, and the transformation of old ones as concomitant conditions for consolidating their health care sector reforms. Policy choice on this matter varied in respect to the priority given to either of these two challenges, as well as in the choice of timing for their implementation. These choices were made according to the vision and the assumptions made by reformers, as well as by the political obstacles and opportunities they found during the reform process. But in

both cases, the successful implementation of these two challenges was a key element in the long and multi-linear process towards health reform.

### 1.1.2 Politics and Health Reforms

The political aspect of health policy change has been acknowledged in the health policy literature describing and analysing health sector reforms but not often fully explored (Foltz, 1996; OECD, 1995; La Forgia, 1993; World Bank, 1993)<sup>3</sup>. For instance, comparing the experiences of member countries, the OECD (1995) notes that as a result of the different political processes in which health reform initiatives are involved, “reform packages have taken different shapes even for countries having similar problems” (OECD, 1995:37).

Indeed, in spite of the fact that the policy contents of health reform initiatives have been converging onto a same *paradigm* (Chernichovsky, 1995) – as described in last section – and have striking similarities in the objectives they seek and the means used to obtain them, their impact has varied widely<sup>4</sup>. In some cases reforms have encountered effective resistance, as is the case of the United States’ 1994 reform efforts (Skocpol, 1995; Steinmo, 1995). In others, such as Chile’s reform (Jimenez de la Jara et al., 1995), the experience has been perceived as so effective in bringing about change, that it has encouraged other countries in the region to follow along the same lines (World Bank, 1993).

However, until very recently, with the exception of the literature that was generated following the failure of the health reform initiative in the United States<sup>5</sup>, the study of the political factors affecting health reforms had remained very limited (Collins, 1989; Freddi, 1989; Bjorkman, 1989; Ferrara, 1989; Hollingsworth, 1989; Bossert et al. 1984; Eckstein, 1960).

There is however, an emerging yet still small body of literature addressing the political aspect of health policy as its main focus (Diderichsen, 1995; Skocpol, 1995, 1992; Wilsford, 1995, 1991; Steinmo and Watts 1995; Schut, 1995; Dholer, 1995; Walt, 1994; Immergut, 1992)<sup>6</sup>. Only a few of these recent studies

concentrate on the political aspect of health reform efforts in the developing world (Cassels, 1995; Chernichovsky, 1995; Walt and Gilson, 1995; Reich, 1994, 1995; Jimenez de la Jara et al., 1995; Gonzalez-Rossetti et al., 1994).

Walt and Gilson (1995) see health sector reform definition as a result of the political economy surrounding policy-making. They argue that during the decades of state-led development, health reforms were largely limited to organisational questions dominated by the medical profession and were largely uncontroversial, while health reform in the 80's and 90's have challenged previously accepted values, that are greatly influenced by the neo-liberal paradigm, and thus became highly conflictive (Walt and Gilson, 1995). It may then be inferred that conflict and confrontation not only have increased, but have surpassed the health policy arena and have trespassed into other political arenas – such as Congress and other areas within the Executive – as the current debate on health reform is reflecting the tensions stemming from the revision of the role of the state and the transformation of state-society relations.

Thus far, the majority of the emerging literature on the politics of health policy has taken a pluralist approach<sup>7</sup> by concentrating on the analysis of societal groups – called stake-holders or **interest groups** – who, perceiving that their interests may be affected, try to influence the policy process in which health reforms are formulated and implemented (Didrechsens, 1995; Blendon and Mollya, 1995; Reich, 1995, 1994; Makison, 1992; Blumenthal, 1992;).

Only a few studies use the new institutionalist approach<sup>8</sup> and concentrate on the analysis of the **political institutions** that structure the health reform process, and their effect on the capacity of these interest groups to effectively influence it (Dohler, 1995; Skocpol, 1995, 1992; Schut, 1995; Steinmo and Watts, 1995; Morone, 1994; Smith, 1993; Immergut, 1992). For instance, Immergut (1992) contends that it is a political factor – the different institutional arrangements – that explains the striking differences in the final outcomes of similar health reform initiatives promoted in Switzerland, France and Sweden. The following section will discuss briefly the political economy models that have informed these studies.

### 1.1.3 The State and the Health Sector

This thesis uses Skocpol's definition of the state as an entity that possesses an administration, laws that guide actions, and organisations and institutions that coerce society, structures the relations between society and the public authority, and structures the relations within society (Skocpol, 1985). In both developed and developing countries the state has been involved in the regulation and financing of health care services. Furthermore, in most countries, governments have been directly involved in the provision of preventive and curative care, as well as in the promotion of health. The range and scope of the tasks and responsibilities of health authorities vary widely from country to country and over time, reflecting different views on the role the state should play in the promotion of health care. Although the boundary between public and private provision of health services has been located differently in different countries, subject both to political swings and financial expediency over time (Mills, 1990), all countries continue to have significant state involvement in the health sector.

Regardless of the distribution of tasks between the private and the public sector – the public/private mix (Mills, 2001) – the state will continue to play an important role in health policy formulation, and this entails negotiating with groups within and outside the state in search of a consensus on the exact nature of health care provision and how to finance it.

From this perspective, health reforms follow the process by which governments<sup>9</sup> formulate and implement public policy, one that takes place as a continuous exchange between the state and different societal actors (Evans, 1992). In order to remain in office, policy-makers<sup>10</sup> need the political backing of key societal groups – a significant proportion of the electorate, organised groups such as labour unions, business communities, etc. – and are thus willing to provide services, distribute resources, subsidies, jobs and issue regulations favouring specific interest groups in order to maintain their support.



However, this exchange of public goods and services for political support among public officials and groups and individuals in society takes various forms depending on the political system in which it operates. While in some political systems policy formulation seems to be entirely reactive to interest group pressure, in others society finds itself reacting to the policy initiatives formulated and implemented by policy-makers who are following their own agenda.

The role of the bureaucracy is a case in point. While in Anglo-Saxon countries it is viewed as a subordinate body to political institutions, in continental Europe and in Latin America, it is a political arena where groups within the state and in society interact, therefore often serving as a converging point for both<sup>11</sup>.

It is within this political context that health policy reform takes place, thus reflecting state-society relations, and other policy issues on the public agenda. A brief discussion follows on different approaches to the state's role and state-society relations on the process of policy reform.

#### **1.1.4 Interest Groups and the Health Reform Process**

The interest group approach – and within it stake-holder analysis – has best captured the dynamics of the bargaining process among different interest groups trying to influence the policy process, and between these groups and policy-makers (Kingdon, 1995; Zajac, 1995; Lindblom et al., 1993; Lindblom, 1988; Olson, 1982, 1965; Wilson, 1980; Peltzman, 1976; Lowi, 1972; Dahl, 1961; Downs, 1972). This pluralist school sees the state as a neutral actor that mediates and reflects the political bargaining among interest groups which are trying to influence the policy arena in order to secure and enhance their own interest (Olson, 1982).

A reform initiative is likely to affect the interests of many of these groups and, according to the pluralist approach, policy-makers will craft policy changes according the level of support they may obtain in exchange for it. These political calculations would lead to very little policy change, as entrenched interests would

press for the continuation of the status quo. Also, there would be very little chance of undergoing policy reform aiming at a more equitable distribution of public resources, as these powerful interest groups would effectively oppose it. A pluralist approach would thus always expect incremental changes negotiated between the state and the strongest coalition in society.

The interest group approach and stake-holder analysis assist in understanding the dynamics of interest group competition or distributional politics, but they offer few answers in the cases where policy-makers, actively pursuing their own agenda, have decided to introduce a reform in spite of visible opposition stemming from powerful societal groups. In Morone's words 'pluralist analysis – calculating the probabilities of action by counting up the interest groups – obscures the influence of the administrative apparatus itself' (Morone, 1994:161).

Health policy analysis often considers the political factor of health reform along the lines of interest group politics in what Morone (1994 ) describes as 'old pluralistic calculations: "groups for" versus "groups against"' (Morone, 1994:223). For instance, Didrehsen (1995) states that health reforms must strike a balance 'between equity and efficiency, between equity and broad political loyalty, and between broad political support and cost control' (Didrehsen, 1995:197). And looking into coalition management and coalition support, La Forgia notes that "although many (social security) and (ministries of health) systems face decreasing popular support, reform may involve expanding considerable political capital to overcome oppositions by well-organised health worker unions and professional associations" (La Forgia, 1993:7). Also following a pluralist view, the World Bank Report on Health (1993) suggests a series of policy interventions that may gradually reallocate resources – for instance, from tertiary to primary health care – in order to maintain the support of middle-income and urban groups affected by health reform.

Reich (1994) has 'mapped' the interest groups in the health arena that may mobilise to support or halt a health reform initiative in order to assess the latter's political feasibility. He takes a pluralist stand suggesting the empowerment of

relatively powerless groups through coalition-making and interest mobilisation as a means to ensure a more redistributive outcome of the health reform processes. Walt and Gilson (1995) also concentrate on the characteristics and political struggle of stake-holders, but go beyond by formally incorporating the political context within which the health reform process takes place in their model.

The pluralist approach has often been used to explain the political aspect of the demise of the US health reform. Interest groups, public opinion, and notably the media are placed at the centre of analysis in Makison (1992), Blumenthal (1992), Blendon and Mollya (1995).

Jacobs (1994) recognises that the role of public opinion varied according to the particular issue – of the health reform plan – that was at stake, but concludes that ‘it can affect agenda setting, interest group leverage over government officials, and policy-makers’ formulation of detailed administrative arrangements’ (Jacobs, 1994:375). In fact, after interviewing policy-makers in Congress and in the Executive branch about the health reform in the US, Hansen and Blendon (1996) concluded that public opinion – and not the institutional setting within which they operated – seemed to them the key factor determining the feasibility of the health reform plan.

In discussing the impact of conservative governments on the welfare state, Marmor and Smeeding (1994) and Pierson (1996), also place significant emphasis on the role of interest groups. However, they give as much weight to the institutional factor in assessing the capability of the British and American governments to diminish the state’s role in social policy. A closer look at the limitations and opportunities offered by the institutional context within which these policy-makers pursue their reform agenda presents a more complete picture of the political factors affecting policy change.

### 1.1.5 The Institutional Context and the Health Reform Process

In order to understand the opportunities and limitations faced by health policy reformers, some studies have shifted their focus of attention away from interest groups in society and have concentrated on the role of political institutions in the interplay among stake-holders, as well as in their mediation between the state and society that takes place during the policy process in what has been labelled the new institutionalism approach.

New institutionalism provides an alternative approach, or counterbalance to pluralism by addressing the institutional influence on policy-making. It brings the state back into the political analysis of policy-making (Evans et al., 1985), but instead of analysing formal institutions as the old statist scholars did<sup>12</sup>, it focuses on "how a given institutional configuration shapes political interactions" (Thelen et al., 1992:6). Thus the focus is not on institutions per se, but on institutional features, or "intermediate-level institutional factors (such as) corporatist arrangements, policy networks linking economic groups to the state bureaucracy, party structures, and the role they play in defining the constellation of incentives and constraints faced by political actors in different national contexts" (Thelen et al., 1992:6).

Also, along with the literature on bureaucratic politics and rational choice models, new institutionalism sees policy-makers as yet another interest group with particular preferences<sup>13</sup> – that go beyond income maximisation and endurance in power<sup>14</sup> – and have a position about the direction public policy should take (Geddes, 1994; Steinmo, 1992; Hall, 1986; Skocpol, 1985; Mann, 1984; Nordlinger, 1981).

According to the new institutionalism, institutions delineate the political arena in which societal groups compete to influence policy, while decision-makers try to pursue their policy agendas. The institutional configuration of a country acts as a filter which allows certain groups and ideas to have access to the policy process, leaving others behind. Institutions determine on the one hand the societal actors'

capacity to influence policy, and on the other, the policy-makers' capacity to act autonomously (Evans, 1995, 1992; Haggard and Kaufman, 1995, 1994, 1992; Steinmo et al., 1992; Hall, 1986; Evans et al., 1985; Katzenstein, 1978).

Thus, a country with strong democratic institutions may permeate the policy process with the demands and interests of a wider range of interest groups that may thus have a voice via congressional representation, lobbying, mobilisation and others, while a country with authoritarian institutions may be able to gain autonomy by insulating its policy-makers from interest group pressure. It would be assumed that by ensuring more room for manoeuvre to its policy-makers, these governments enhance their capacity to pursue policy change.

However, relating the institutional framework to the outcome of policy reform is not as self-evident as it may appear. Studying different types of political regime in Latin America, Remmer (1990) showed that there did not seem to be any empirical relation between these and the state's capacity to promote policy change. Also, the content of policy reform cannot be automatically associated with a specific institutional configuration.

The distributional outcome of health reform is a case in point. Pluralist studies tend to show that in a democratic regime there is a high possibility of powerful interest groups *capturing* the state<sup>15</sup>, and thus perpetuating an inequitable status quo. However, there have been instances in which the same democratic institutions have given greater access to politically weak groups who have thus been able to influence policy in their favour through mobilisation, or have been favoured by policy results in spite of their little capacity for organised political action (Immergut, 1992).

In other words, states with non-democratic institutions have promoted policy change aimed at redressing equity imbalances as much as they have used their power to maintain an inequitable status quo (Remmer, 1990; Haggard, 1990; Haggard and Kaufman, 1989).

Thus some studies analysing the political element of health policy reform have turned to institutional analysis in trying to understand the political process behind health policy change and assessing the political feasibility of such change. These studies shift the focus of attention from interest groups in society willing to influence the health reform process, and concentrate on the role of institutions in the bargaining process between the state and society. The interaction between the societal groups that have a stake in health policy and the decision-makers involved will be mediated by a given institutional framework defining state-society relations. And this will greatly determine what services are provided to whom and how, and who is to carry the costs of the final policy choice.

Immergut (1992) puts institutions at the core of health reform analysis by saying that 'the political context is an institutional context' (Immergut, 1992:3). Institutions, both formal and informal are the rules of the game by which interest groups compete to influence the health reform process. They will also determine the policy choices decision-makers have, as well as their margin for manoeuvre, thus establishing the 'political logic for each nation' (Immergut, 1992:4).

She compares the health reform processes in France, Sweden and Switzerland and concludes that their different institutional contexts explain why the outcome of their health reform process was so different, despite the fact that these countries shared common goals and had similar reform proposals at the start of their health reform process. As Immergut explains 'the initial aims of policy-makers and interest groups were quite similar across the cases, but because they pursued these goals within different institutional frameworks, they had different chances of success, and different political strategies made sense' (Immergut, 1992:79).

In stating that the chances of success of interest groups – and policy-makers – depended on the institutional framework within which they participated in the health reform process, Immergut (1992) makes a radical departure from pluralist approaches. According to her approach, the power an interest group has – and thus its potential to influence the health reform process – does not depend solely on its characteristics – number of members, level of organisation, geographical

concentration<sup>16</sup> – but on the institutional context within which it operates. In other words, institutions will strengthen or make redundant the political resources an interest group has to pursue its agenda.

In studying the politics of social policy in the United States, and later on, reacting to the failure of the health reform efforts in the 1990's, Skocpol (1992, 1995) has also placed institutions at the centre of the analysis. The importance given to institutions in the political analysis of health reform has been echoed by other scholars, such as Morone (1994), who contends that the recent US health reform attempt did not have a careful institutional framework, or Steinmo and Watts (1995), who after making a historical review of health reform efforts in the US, conclude that '...reformers who want real reform rather than a continuation of the pattern of buying off interests and avoiding making tough choices should focus their efforts on reforming American political institutions rather than designing ever more sophisticated reform strategies...' (Steinmo et al., 1995:368).

In other industrialised countries, Wilsford (1995) looks at Germany, Japan, Canada and Great Britain and contends that to succeed in reforming their health care systems, policy-makers have tried to increase state autonomy in order to counter the interest group mobilisation of providers. They have done so by carefully using the opportunities offered by their particular institutional contexts.

For instance, in tandem with Smith (1993), he sees the latest British health reform experience as an example where institutions influence the policy outcome. 'When structures are strong and the high civil servants and functionaries who inhabit them can engage in a focused, discretionary decision-making, interest groups are reduced to a reactive posture regardless of their organisational strength and cohesiveness' (Wilsford, 1995: 603). In this analysis, Wilsford (1995) concludes that state autonomy in the process of health reform is as much a result of the institutional framework, as it is a result of the policy-makers who are leading the process, the change team.

### **1.1.6 The Health Reform Process**

It is in this institutional context that health reforms are evoked through a policy process. The policy process is the series of events that a reform initiative follows from the definition of the problem and its incorporation to the public agenda, to the consolidation of the intended policy change<sup>17</sup>. The policy process rarely takes a sequential and unilinear form, but for analytical purposes, it may be ‘anchored’ in six crucial stages<sup>18</sup>: problem definition, reform formulation, reform legislation, reform regulation, reform implementation and reform consolidation.

As the policy process takes its course within the institutional framework of the country, the reform will pass through a number of points in which its substance may be altered, and even the very chance of it being implemented at all may be put at risk. These crucial stages of the policy process occur at different points in the institutional framework, such as the Executive, the Congress, and the agencies in charge of its implementation.

On each of these *policy nodes* (Immergut, 1992), the reform is affected by those actors who are able to access these points and influence the policy process during that particular stage. The actors that participate in decision-making at each policy node, as well as those who manage to influence them, are not the same at each stage. But also, the same actors may have a different role at the different stages of the policy process. Their agenda and their power will be different on each policy node, and their potential to influence the content of the reform as well as its feasibility will vary accordingly (Immergut, 1992; Thelen et al., 1992; Skocpol, 1995; Steinmo, 1995;).

### **1.1.7 Change Teams and the Health Reform Process**

If policy definition does not necessarily reflect the aggregation of societal interests – or those of particular powerful interest groups – how and why policy-makers define policy change remains an open question. This calls for the need to focus the analysis on the group of policy-makers in charge of policy reform, since in



defining policy change, this group needs to take into consideration the political context in which it operates, and also to react to interest group pressure trying to influence its reform agenda. In other words, all the political factors affecting health reform are brought to relevance in the reformers' decision-making room, where the political context on the one hand, and interest group politics on the other, converge.

A group of political economy studies on policy change in the economic sector has concentrated on the reformers themselves (Schneider, 1991; Waterbury, 1992; Geddes, 1994; Evans, 1995). They see policy-makers as independent actors pursuing their own reform agenda, and not simply reacting to interest group pressure. This approach has great potential for the analysis of health reform, since it may help explain why despite strong resistance to policy change stemming from powerful stake-holders, reform does occur.

To explain how and why a policy is formulated and what impact it has, this analysis focuses on the decisions taken by policy-makers within the state, as well as their political competition within the limits of the institutions they operate in. The reformers' profiles, their policy agenda, their potential for manoeuvring within the state, and their relations with other groups in society play a significant role in the state's capacity to bring about policy change. In Geddes' words: 'To understand why governments sometimes undertake radical and risky reforms, scholars need to think about who the people are who make policies, what their interests are, and what shapes their interests' (Geddes, 1995:198).

Thus, using the rational choice model<sup>19</sup>, Geddes (1994) presents the state as a collection of self-interested individuals, and policy choice as a result of these decision-makers' maximising strategy in furthering their careers. In other words, policy-makers as rational individuals, will make policy decisions based on the incentives they perceive to secure a successful career.

If the state is made up of a collection of individuals or groups pursuing their own policy agendas, it cannot be assumed to be a single actor with one policy agenda.

In fact, Evans (1995) argues that “the state ‘wants’ because some group of individuals within the state apparatus has a project. This does not mean that the project is merely a reflection of their personal biographies or individual maximising strategies. It does mean that their project may well be opposed by others elsewhere in the state and that the definition of what the state ‘wants’ is the result of internal political conflict and flux” (Evans, 1995:19).

Stemming from the bureaucratic politics school<sup>20</sup> Schneider (1991) focuses on the political struggle that takes place within the state as different groups of policy-makers or *bureaucratic factions*<sup>21</sup> compete to influence policy definition and implementation. This type of analysis tries to see how policy-makers develop strategies to pursue their policy agenda within the political constraints determined by the institutional framework in which they operate. In Evan’s words, “state managers do not engage in disembodied maximisation. Their decisions depend on an institutional context composed of complex, historically emergent patterns of interaction that are embodied in societal structures and taken for granted by the individuals who work within them” (Evans, 1995:28)<sup>22</sup>.

The particular groups of policy-makers in charge of formulating and promoting policy reforms have been referred to as ‘change teams’ (Waterbury, 1992). A change team consists of a small group of *technocrats*<sup>23</sup> isolated from other groups in the political arena and whose capacity to operate and pursue policy change depends on the support of a high-ranking public official (Waterbury, 1992). Change team members belong to the top echelons of the state bureaucracy, train in prestigious universities, follow predominantly public careers, and circulate rapidly through many different agencies (Schneider, 1993). They share a common view on policy priorities, and a similar ideology in what pertains to the role of the state in public policy.

Change teams have been described as technocratic<sup>24</sup> (Waterbury, 1989; Collier, 1979), because their leverage relies on the mix of skills their members bring to them – partly technical, partly political – which allows them to operate effectively both in policy formulation, as well as in political manoeuvring (Schneider, 1991;

Geddes, 1994). Silva (1996), Smith (1993) and Evans (1995) note that part of their success in bringing about policy reform is precisely their ability to establish links and consolidate policy networks with key interest groups in society<sup>25</sup>.

Scholarly attention on change teams grew as these were formed in different countries to formulate and implement policy reform in the context of economic reform during the 1980's (Nelson 1990; Schneider, 1991, 1993; Evans, 1992; Geddes, 1994)<sup>26</sup>. These studies depart from the assumption that many features of public policy can be traced back to individual and micro-level decisions at the state level (Schneider, 1991). They bring back the concept of politics within the state by examining these teams' leverage within the state as a means to understand their influence on the reform's policy outcome (Downs, 1964; Schneider, 1991; Geddes, 1994).

The act of creating a change team, empowering it and placing it in a position to lead a reform process can be considered as a strategy in and of itself. Waterbury refers to them as "efficient instruments government leaders may use to promote socio-economic reforms" (Waterbury, 1992:192). A government resorts to this strategy as a means to augment its autonomy from interest group pressure – stemming from both within and outside the state – and thus enhances its chances of bringing about policy change. In resorting to the creation and use of a change team, governments seek to articulate and pursue a series of political strategies geared at enhancing the political feasibility of their reform agenda.

Change teams have the explicit mandate to circumvent the regular bureaucratic channels for inter-sectoral policy formulation and implementation, with the double purpose of speeding up the reform process and insulating it from political interference (Geddes, 1994). This responds to the technocratic belief that policy decisions should not be subject to political bargaining.

The formation of change teams is appealing to policy-makers because they are capable of processing information and making decisions quite efficiently. But, however politically autonomous, they remain dependent on the institutional

instruments for policy implementation (Haggard, 1990). Also, their very isolation may sever their ties with any potential support coalition, thus exposing them to any changes in the leader's agenda – in view of his political calculations. Also, given the characteristics and particular isolated position of these teams within the institutional setting, their survival in view of leadership turnover is at best improbable (Waterbury, 1989; Nelson, 1990; Evans, 1992; Walt, 1994).

Change teams can be located at different points of the policy context, depending on the institutional framework of the country (Schneider, 1991; Geddes, 1994; Walt, 1994), and may be active at several stages of the policy reform process. For instance, in a presidential system, change teams may be active as informal committees close to the executive power, while in a parliamentary system it may be a commission in charge of drafting legislation. The change team can be a formal part of the civil service<sup>27</sup>, in the form of a planning commission, an ad hoc inter-agency task force, or an advisory group (Walt, 1994).

The institutional context also plays a significant part in determining whether a government can resort to change teams as a policy strategy, and also whether once formed, these change teams can operate. In their account of how economic change teams were able to implement their policy agenda despite societal opposition – including resistance from powerful economic interest groups – Conaghan and Malloy (1990) pointed out that “the power to implement the programs was not simply a function of the mental toughness of the teams. Institutional and political factors permitted the insulation of the economic teams from direct societal pressures”(Conaghan et al., 1990: 20).

They contended that this policy style was related to the tradition of centralised Executive power in Latin America, where the legal power allocated to the Executive allowed reform teams to develop and enact economic policy virtually without consulting their Legislatures and political parties. So, in the case of Peru, Ecuador and Bolivia, the technocrats' policy prescriptions were mostly applied through Executive decrees, and political parties were excluded from the policy process. The technocrats viewed party leaders as technically incompetent and

feared that their involvement in the policy process would undermine their goals. At best, politicians were called upon to help broker a minimum level of consensus for the reform agenda (Conaghan and Malloy, 1990).

In analysing the political economy of reforms in other developing countries, Grindle and Thomas also note that “(in) countries in which the process of decision-making is highly centralised in the Executive, much policy discussion may be relatively closed and even secret, (and that such) characteristics tend to increase the importance of technocrats in decision-making” (Grindle and Thomas, 1991:97).

In the case of health reforms, governments have also resorted to the use of change teams to pursue and maintain control over their reform agenda. Thus, the analysis of these groups’ characteristics, their composition, their background and networks, as well as their incentives, are key elements in understanding the health reform processes. Also, the analysis of the opportunities and limitations they face in pursuing their health reform agenda, and the assessment of the political strategies they use in response to them, can provide an invaluable body of knowledge to inform policy advice in support of health sector reform.

However, very little formal analysis has been undertaken on these policy-makers in charge of formulating and leading health reforms. Wilsford (1995), Pierson (1996) and Smith (1993) mention tangentially their role as one of the elements determining the degree of the state’s autonomy vis-à-vis interest groups seeking patronage and resisting policy change, but do not focus on them as the main thrust of their analysis.

Finally, the political economy literature on change teams and first generation reforms has noted that while significant progress was made in areas of the economic sector where reforms could be brought about with changes in rules and incentives, “progress has been far slower with institutional and non-price reforms” (Nelson, 1989:11). Graham and Grindle (1999) also point to the fact that reforms requiring institutional transformation have proven more complex and need more

negotiation (Graham and Grindle, 1999). Nelson suggests that this might be due to the *orthodox paradox*: “the attempt to use the agencies and personnel of the state to diminish or dismantle their own power” (Nelson, 1989:10)<sup>28</sup>.

Thus the use of change teams to pursue health reforms requires careful analysis. Given that in Latin America the state plays a major role in social services and health service provision, second generation reforms will require “reforms in the organisation and roles of government bodies (and) in changing attitudes to and the working relationship with the private sector” (Batley, 1999:10). Thus health change teams will necessarily face the “orthodox paradox”: To successfully pursue health reform, they will have to rely on salaried health manpower and health sector officials to implement policy change. The question remains open as to how the health change teams fare in pursuing health reform given that in Bjorkman’s words, “(t)ry as they will, the politicians and the bureaucrats cannot replace the functions of the health professionals” (Bjorkman, 1989:33).

## 1.2 Analytical Framework

This thesis focuses on the political feasibility of health reforms. To do so, it concentrates on the state’s capacity to pursue health policy change with two working hypothesis. The **first hypothesis** used was that the state’s capacity to bring about policy change, and thus the political feasibility of health reform, is affected by three elements:

1. The *political context* of the country: its political system, its institutions, its rules of governance – formal and informal – and key actors and their interrelation.
2. The *policy process*: The series of stages that are undertaken to bring about change, starting at reform formulation and finishing at its consolidation; the policy nodes in which these occur and actors within them.
3. The *change teams* that are formed and used as a means to increase the state’s capacity to bring about the reform; their characteristics, political manoeuvring and choice of strategies.

The argument runs as follows: When a *health reform* initiative reaches the public agenda, actors within and outside the state interested in it will take positions in favour or against it. The country's *political context* presents both opportunities and obstacles throughout the reform's *policy process* for these actors to influence the reform. Policy-makers promoting the reform will choose political strategies to respond to these opportunities and limitations, and thus increase the *state's capacity* to bring about policy change. Among these strategies, they may create a *change team* in order to streamline activities related to the reform's policy formulation, political manoeuvring, and the strategies aimed towards enhancing the *political feasibility* of the health reform.

A complementary **second working hypothesis** is therefore that the use of *change teams* in health sector reform is a distinctive political strategy aimed at increasing the state's capacity to promote health policy change, and that it can be singled out as such by both participants and observers of the health reform process.

The argument here is that health *change teams* are formed and empowered by senior policy-makers with a health reform agenda and put in charge of formulating and leading it throughout its policy process. The opportunities and limitations present in the political context on the one hand, and the state's response to them on the other, converge in these change teams. Therefore, the state's capacity to pursue health reform will depend, in a significant manner, on the change team's political manoeuvring and choice of strategies to bring about policy change within the political context in which the reform is to take place.

The change team's capacity for strategic political manoeuvring during the health reform process may be as important for successful implementation as the team's technical capacity to formulate sound policy, since change teams resort to a combination of technical skills and political manoeuvring to buttress support around the reform initiative and enhance the probability of successfully challenging resistance to change,

Thus, the analytical framework (see table 1.1) is constructed with 3 overarching variables affecting the state's capacity to bring about health policy reform: 1) the political context; 2) the policy process; and 3) the change teams.

<b>Table 1.1 : Political Dimension of Health Sector Reform</b>		
<b>Analytical Framework</b>		
<b>I. Political Context</b>	<b>II. Policy Process</b>	<b>III. Change Teams</b>
<ul style="list-style-type: none"> <li>• <b>Political system</b>  Institutional configuration. Formal attributions of relevant institutions and actors.</li> <li>• <b>Formal/informal institutions structuring politics</b></li> <li>• <b>Political map of key actors</b>  Political parties Business Labour Bureaucracy Civil society</li> <li>• <b>Contextual circumstances</b>  Economic Social Political</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Anchor stages of policy process</b>  Problem definition Policy formulation Legislation Regulation Implementation Consolidation</li> <li>• <b>Key policy nodes</b>  Executive Congress Implementing agency</li> <li>• <b>Relevant actors in key policy nodes.</b></li> <li>• <b>State-society relations in policy process.</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Formation and use of change teams</b>  Characteristics: Location Expertise mix Previous experience Ideology Perception of state society relations</li> <li>• <b>Change team political manoeuvring</b>  Vertical networks Horizontal networks State-society networks</li> <li>• <b>Change team choice of strategies</b>  Speed and scope Brokerage in Congress Choice of legislation Policy dialogue Transition strategies Inducing change</li> </ul>



### 1.2.1 Political Context

The political context is defined in this thesis as the political system of the country, its formal institutions and informal institutional features, its party system, and state-society relations. It lays out the framework within which policy-makers and actors operate during the policy process, and maps the position of influence of the latter – business, labour, the bureaucracy and groups in civil society. It also includes the formal and informal rules of the game that present opportunities and obstacles for policy-makers and societal groups to press for their agendas. Finally, it looks into any major economic, social and/or political circumstances that might potentially affect the health reform process.

The boundaries in this variable are established by focusing only on those aspects of the political context relevant to the health reform process. An emphasis is placed on the country's institutional features – both formal and informal – as they establish the rules of the game for state-society relations and thus the opportunities and limits for actors involved in the different stages of the health reform process.

#### **Indicative research questions were:**

- What are the nature and characteristics of the country's political system?
- What are the nature and characteristics of the formal institutional context?
- What are the formal attributions of the institutions and actors relevant to the health reform process?
- What were the *formal* rules (or institutional features) of the political system governing the interaction among actors in and outside the state as well as state-society relations?
- What were the *informal* rules (or informal institutional features) operating in the interaction among actors in and outside the state as well as state-society relations?

- Who are and what are the principal characteristics of the key actors in the political context – such as politicians, policy makers, elite groups, interest groups, social organisations, among others?

### 1.2.2 Policy Process

The policy process is defined in this thesis as the series of events that a reform initiative follows from the definition of the policy problem and its incorporation in the public agenda, to the consolidation of the intended policy change. This variable is operationalised by defining six “anchor” stages in the reform process<sup>29</sup>:

1. problem definition
2. reform policy formulation
3. reform legislation
4. reform regulation
5. reform implementation
6. reform consolidation

The period/place in which these stages of the reform process take place will be called *policy nodes*. Policy nodes are the points in the political system in which a reform initiative is exposed to being derailed or have its policy content significantly modified. It is not a physical entity, but instead “a point of strategic uncertainty” or a “window of opportunity” – for both those in favour and those against change – that may occur at any given moment of the reform policy process. In other words, each stage of a reform process evolves in a particular location within the political system, and thus a policy node is the *stage* of the reform process and the *place* in which it occurs, where the reform can be significantly altered<sup>30</sup>. Examples are the Executive, Congress or the agency in charge of implementing the reform.

The stages of a reform process may not necessarily occur in a unilinear process, but instead may happen simultaneously in different *policy nodes* in the political system. Depending on the political system and its rules of the game, a different set of actors will have access to these policy nodes. Thus, key actors are

operationalised as those who are present in these policy nodes, or who are able to influence the health reform process as it passes through them. The other set of actors relevant to the analysis are those who, while not having access to the policy nodes, may be affected by the health reform, such as health service providers in the public and private sectors.

**Indicative research questions were:**

- When and where does problem definition occur?
- When and where does policy reform formulation occur?
- When and where does legislation occur?
- When and where is regulation defined?
- When and where does policy implementation occur?
- When and where does reform consolidation occur?
- Location and characteristics of the *policy nodes*.
- What elements of the reform are at stake in these policy nodes?
- Who are the relevant actors in the policy nodes and their interaction?
- Who has access – and who has not – to the policy nodes?

### **1.2.3 Change Teams and their Political Strategies**

The health change team is defined in this thesis as the group of policy-makers formed and empowered to lead a health reform. The study works on the assumptions that its creation is a political strategy in and of itself used by governments as a means to “manage” the technical and political requirements of a health reform. Thus it is expected that the change team’s characteristics, its ability for political manoeuvring and its choice of strategies will have significant influence on the state’s capacity to pursue health reform.

Among these **characteristics** are the educational and professional background of change team members, which determine their pool of skills they count on to manage the health reform. Its members’ previous policy experience will inform

the team in its choice of the reform's policy content and the political strategies to promote it.

Once formed and empowered, change teams engage in political manoeuvring in order to embed themselves within the state. They will thus try to ensure their political leverage, and access to different points of decision-making by securing the political support of senior policy-makers and politicians (**vertical networks**). The change team's existence, location and capacity for manoeuvre will be dependent upon these vertical networks.

The change team will also establish channels of co-operation with same-level peers in other government agencies (**horizontal networks**). This will allow it to exchange strategic information at the right time and join efforts with fellow reformers working in other sectors. It will also allow them to make their case in different policy arenas.

Finally change teams may establish selective contacts with groups in society in order to obtain information and knowledge particular to the health sector and to buttress political support behind their reform agenda (**state-society networks**). These state-society networks are seldom spaces for policy dialogue. Instead, change teams resort to them sporadically and unpredictably, and always maintaining firm control over these groups' access to policy formulation and decision-making around the health reform.

Finally, in order to enhance the political feasibility of their agenda, change teams make a series of strategy choices affecting different aspects of the reform process as well as its policy context, such as:

- The speed and scope of the reform agenda
- The type of brokerage in Congress
- The choice of legislation for the reform
- The type of policy dialogue
- The transition strategies
- The means to induce policy change

A few examples of the choices change teams face are presented here to clarify this variable. However, it must be noted that these choices are presented as extreme, oversimplified, dichotomous options for purposes of clarity, but that in reality decisions made on these options only vary in degree.

In the case of *speed and scope of the reform agenda*, change teams need to choose between formulating one-time comprehensive change to be implemented in the short run, versus incremental change to be implemented in a series of progressive stages in the long run. Change teams are also expected to respond to the particularities of the political context in which they operate in order to define their *brokerage strategies in Congress*. In their *choice of legislation*, change teams may choose from legislative amendments, Executive decrees, internal administrative decrees and changes in regulation as mechanisms to bring about policy change. In *policy dialogue*, change teams confront the option to pursue health reform promoting the participation of interested actors, or, on the opposite side, insulate themselves and avoid the influence of these actors.

Given that change teams are aware that their mandate to lead reforms will only last while they count on the support of the senior policy-makers who empowered them, they will resort to strategies to ensure the continuity of the reform process once they have left office, and thus augment the reform's chances of consolidation. Among these strategies, they may rely on new regulation and budget reallocation to ensure the continuity of their policy changes, or may also try to appoint pro-reform policy-makers in positions key for the continuity of the reform – among others.

**Indicative research questions were:**

- Can a change team be identified among the groups of policy-makers involved in the health reform?
- What is the change team's configuration – profile of members, expertise mix and previous experience, ideology and others?
- Where is the change team located in the political context?
- Where does its political backing stem from?
- Does it have political leverage?
- What are the identifiable networks the change team counts on as a means to secure political backing (vertical, horizontal and state-society)?
- What are the identifiable strategy choices the change team has made to pursue health reform?

**1.3 Methods**

Thus far this thesis has established two main issues to be explored. The first working hypothesis argues that the political feasibility of health reform is dependent on three elements: the political context; the policy process; and the change teams. The second hypothesis claims that the use of change teams in health sector reforms is a distinctive political strategy aimed at increasing the political feasibility of these reform initiatives.

This thesis focuses on reform periods in Mexico (1994 - 1999) and Colombia (1990 -1994) in which change teams were involved in the process of formulating and implementing health policy change. While in both countries the health reform process continues and has yet to consolidate, these periods represent the turning points in both health reforms when major policy changes were introduced, legislated, and implemented – while other components of the health reform initiatives lagged behind. The implementation of these health reforms in Mexico and Colombia continue to have a highly political element, and their evolution can be a source of important lessons on the politics of health reform.

Given that the political analysis of health reform is a new field which is yet to build a significant core of applied theory, most of the scholarly work informing this thesis and its methods stem from the political economy of policy reform in other sectors – particularly state reform and economic liberalisation. By applying this body of knowledge to the analysis of health reform, this thesis aims at contributing to the expansion of the political economy field in health policy analysis. This section establishes the “working boundaries for approaching the problem” (Altheide and Johnson, 1994:485) and explains the methods that were used in conducting this thesis and the judgements that were made to choose them based on the literature review on qualitative research.

### **1.3.1 The Comparative Case Study Approach and Process Tracing**

This thesis uses a *comparative institutional approach* (Evans, 1995). It is institutional because it focuses on how and why policy-makers interact within the institutional constraints and opportunities present in the political context in which health reforms take place, and relates these findings to the political feasibility of health policy change. It is comparative because it looks for variations in similar policy reform processes – in Colombia and Mexico – as the basis to understand the relevant elements determining the political feasibility of health sector reform.

Garson (1976) claims that the use of case studies may be justified on several grounds, among which – and relevant for this thesis – is their usefulness in explaining a particular phenomenon that may not lead to supporting generalisation, but may provide insights useful for further research efforts. Case studies can also be a method of obtaining information or concrete illustrations of a particular issue under study. The researcher looks into both what is common and what is particular about each case, and the result of each case study will be unique given its nature, its historical background, its political context, and, significantly those informants through which we come to know about it (Stake, 1994).

Thus, in order to undertake relevant comparative analysis, the researcher needs to choose how much and how long of the complexities in each case to study when

gathering data on these aspects. To do so, the researcher may use comparative analysis as “a powerful conceptual mechanism fixing attention upon the few attributes being compared and obscuring other knowledge about the case” (Stake, 1994).

Van Evera (1995) argues that case studies can serve five main purposes: testing hypotheses, creating theories, identifying previous conditions, testing the importance of these conditions, and explaining cases of intrinsic importance. This thesis employed the case study method, and its qualitative selection of cases (non-probabilistic sampling), to test the working hypotheses and identify whether the relationship between the independent variables (political context, policy process, change team) and the dependent variable (political feasibility of health reform) were significant to elaborating new general associations that were not previously apparent in the field of public health.

The use of only two cases (small sample) made inquiring about the details of the variables and their interaction feasible, providing the conditions to gain insight into the casual processes presented in the hypotheses that were being tested. In contrast, a large number of cases (large sample) would have risked providing little or no new insight into the detailed causal process proposed in this thesis’s working hypotheses. In general, the simultaneous analysis of a large number of cases (large sample) tell more about whether hypotheses *hold*, rather than *why and how* they hold (Weiner, 1975). In this case, the *how and why* were prioritised, and therefore only two cases were selected. If the findings support the working hypothesis, then further cases can be explored in order to test the hypotheses further and see if generalisations about these hypotheses can be made.

Another advantage of case study methods is that they allow the researcher to “process trace” the variables that are being studied by following their interaction in their specific context (George and McKeown 1994, King et al., 1994). In *process tracing*, the researcher explores the chain of events or the decision-making process by which initial case conditions are translated into case outcomes (King et al., 1994). In this manner, the cause-effect links that connect the



independent variables (context, policy process and change team) are unwrapped and divided into smaller steps; so that observable evidence may be analysed at each stage.

This was particularly useful in this thesis, since the state's capacity to pursue health reform and its use of change teams were analysed against the backdrop of the reform's policy process. And to do so, the latter was divided in smaller units of analysis (*policy nodes*) through which the interaction between state and society, and policy-makers and interest groups could be observed. Thus, process tracing helped define the boundaries of the research and limit the complexities observed in the cases under study, allowing for the particular phenomenon being explored to surface.

### **1.3.2 Selecting Mexico and Colombia**

There is no consensus on a method or a single set of criteria for selecting case studies. Stake (1994) contends that cases are not necessarily selected based on their representativeness, but instead, based on their potential to offer an opportunity to learn about the phenomenon of interest. The literature on methodology for social science and comparative politics points at six criteria useful for selecting the case studies (Eckstein, 1975, King et al., 1994, Van Evera, 1995).

Table (1.2) does not exhaust the logical possibilities, but includes all possibilities that were consistently mentioned in the literature that was reviewed, making a case for their selection of Colombia and Mexico for comparative analysis.

<b>Table 1.2: Selection of Case Studies</b>		
<b>Case selection criteria</b>	<b>Colombia (1990 – 1994)</b>	<b>Mexico (1994 – 1999)</b>
1. Data richness.	Vast amount of scholarly work, primary and secondary sources and a good climate to conduct interviews.	
2. Identifiable values on independent variables and dependent variables. 3.	Variables were not difficult to identify and research.	
3. Resemblance to current policy-problem cases.	Health reforms were an issue on the political agenda, and resembled the dynamics of other current policy problems.	
4. Ease of controlled comparison between cases.	Comparison was feasible due to the long list of similarities and differences found in both cases.	
5. Appropriateness for replication of previous tests.	Conclusions about these particular reforms are not statistically representative (small sample). However, they may show features that are common to other countries in the region and could be the basis for further comparative analysis.	
6. Feasibility to conduct fieldwork.	Funding was sufficient to conduct the appropriate fieldwork. Language and access were not problems.	

The selection of Colombia and Mexico as case studies had various advantages. They are both middle-income countries in the Latin American Region with a long history of state intervention in the health field. They have also undergone important structural reforms affecting their economic, political and social spheres. Both countries have resorted to change teams in these reform efforts, and did so as well when promoting health reform. The fact that Colombia succeeded in moving on to the implementation stage of its health reform, while Mexico only achieved mixed results thus far, made the case study comparison relevant, as the use of

change teams can be analysed against a backdrop of positive and mixed-result scenarios.

At different times during the last decade, Colombia and Mexico – as many others in the region – have attempted important policy reforms aimed at redressing imbalances in access to health service delivery and correct pervading inefficiencies. However, health reform initiatives met with great resistance from vested interests strongly defending the status quo. The degree of these groups' success in halting or significantly altering health reform efforts has been largely determined by the three factors that this thesis explores: the political context, the policy process, and the strategy choice of the health change teams.

The two case studies of Colombia and Mexico were also selected on the grounds that they shared in their reform agenda a reconsideration of the role of the state and of the market in the provision of health services. As a result, both countries envisioned the creation of a plurality of new providers that, under market mechanisms and state regulation, would share the responsibility for health provision with the old state agencies, thus radically transforming the health systems that had been operating as state services since the post-war era.

While the change teams in charge of health reform in Mexico and Colombia were similar in composition, ideology, and policy experience, their political manoeuvring and choice of strategies varied and so did their results. Colombia has successfully started the implementation of its health reform, while Mexico has thus far attained mixed results. Given the similarities on the political strategies used to pursue health sector reform in these two countries, and the difference in the results attained thus far, the comparative analysis of these two cases tries to shed some light on the factors affecting the political feasibility of health sector reform.

### 1.3.3 The Research Process

Between mid-1996 and mid-1997 I undertook a thorough review of the literature on both health reform in general, and theoretical approaches to the political economy of policy reforms, and designed the study around the analytic framework as depicted in section (1.2). During this period I was also able to explore the immense primary data base of Colombian documents housed in Harvard University, and undertake some preliminary interviews with experts on both Colombia and Mexico who were in Boston at the time (see appendices I and II for technical details on the health reforms in Colombia and Mexico).

The **document review**, synthesis, interpretation of primary and secondary sources, published and unpublished, was enriched by generous colleagues in both countries, who shared valuable information, including official and unofficial government documents, policy drafts and proposals among others. I also had access to secondary sources produced by think-tanks such as Funsalud in Mexico and Fedesarrollo in Colombia. Local newspapers and magazines were another source of information and were useful in complementing such documents.

The main source of data for this thesis remained the official and unofficial government documents that contained the health reform proposals and/or elements referring to them. These included government programs, memos, internal reports, public dissemination documents, notes, transcripts, drafts of proposals and law bills among others. These **documents** needed careful **interpretation**. Hodder points out that “texts have to be understood in the context of their conditions of production and reading” (Hodder, 1994). Given that the use of information was in itself a strategy for political manoeuvring, document contents could not be taken at face value, but instead had to be analysed in the light of the circumstance in which they were prepared, as well as that of the audience they were directed to<sup>31</sup>. In many instances, documents – or at least their contents – were discussed in interviews in an effort to gain insight into their meaning and their use beyond what they communicated in their writing.

**Interviews and informal meetings** with informants were an extremely important part of the methods used, with some interviewees being seen more than once. The two main objectives for undertaking interviews were:

- To reconstruct the inside political history of the health reforms during their initial periods, and
- To identify and analyse the perceptions of the actors who were directly involved in the health reforms

In the case of policy makers – the majority of those approached -, the interviews explored their participation in, and interpretation of, specific decisions affecting the health reform processes, as well as their perceptions of the institutional opportunities and limitations for promoting health policy change (see appendix V for an example of interview schedule). The career path of these policy-makers was examined by getting biographical data obtained through official sources or through interviews.

Stake (1994) points to the fact that once the case studies have been selected “there are subsequent choices to make about persons, places and events to observe” (Stake, 1994:244). In choosing who to interview in case studies, the criteria of access should have a significant role. Thus, just as was the case in the case selection, “the primary criterion is the opportunity to learn” (Stake, 1994: 244). Thus, *convenience sampling* was used to approach the first interviewees during preliminary fieldwork. *Convenience sampling*<sup>32</sup> is obtained “when the researcher selects whoever is most conveniently available for the interview” (Goel, 1988:104). However, once I gained more depth and knowledge in my research topic, I resorted to *judgmental sampling* in choosing - to the best of my capacity and the access I had - the next group of informants. *Judgmental sampling* is done when the topic of interest involves top leaders in a community and thus a random sampling would be inefficient (Goel, 1988)<sup>33</sup>. This sampling process was further aided by *snowballing* (Garson, 1976) also known as *chain sample* (Garson, 1976). This consists in starting with a few respondents – based on the access one has to them, and then asking these respondents to name other individuals for

interviewing, who in turn are asked to recommend others – thus *multi-stage sampling* (Garson, 1976).

Garson (1976) warns that if non random sampling such as this is used, it cannot be assumed that the resulting group of informants forms a representative sample. However, Stake points that the important factor here is “assuring variety but not necessarily representativeness” (Stake, 1994: 244). Thus, following this criterion, a total of 43 persons were interviewed in both countries stemming from the players, the relevant stake-holders, the interested observers and some of the country-specific experts. Key informants were policy-makers who participated in all or a fraction of the health reform process, as well as other relevant actors in and outside the state, who were involved in supporting or confronting the reform initiative.

Among the actors interviewed were the policy-makers at the head of the Health Ministry in Colombia during the reform process and the Mexican Social Security Institute in the case of Mexico, the Minister’s advisory staff in Colombia and policy-makers in planning units within the Ministry of Health in Colombia. Their peers and counterparts in other ministries, such as the National Planning Department (DNP) in the case of Colombia, and the Finance Ministry in the case of Mexico were also interviewed along with heads of the institutions participating or being affected by health policy change or other members of the Cabinet.

A second group of interviewees were actors active in politics, such as members of the parties in power and in the opposition, lobbyists and consultants involved with the reform process for the case of Colombia, as well as business and labour leaders in Mexico. These actors proved crucial in assessing the political weight and the nature and the role of the actors in the first group. Other key actors with a stake in the reform process who were interviewed were members of multilateral organisations and donors participating in the support of health sector reform for both cases. Union leaders of the health work force and health service bureaucracy and leaders of the peak associations, such as medical associations were also interviewed for both cases.

Finally, a third group of interviewees included academics, policy and political analysts whose articulated account of the political economy of Colombia and Mexico, as well as the policy process enriched the background work done in these areas with primary and secondary sources. Members of specialised think tanks in the health sector were particularly relevant, not only because of their familiarity with the process, but because on many occasions they had been direct actors as policy-makers in previous reform attempts. This is due to the fine line between academic life and government activity that has characterised state reforms in the last two decades in Latin America.

A total of 157 persons were contacted in both countries – 65 in Colombia and 92 in Mexico. The fact that only 43 encounters were recorded as interviews may give the misleading impression that very few of these actors were open to share their information and experience for this thesis (see appendices III and IV for details). Instead, a number of these individuals kindly volunteered their perceptions, information and material during informal encounters that could not be recorded as formal interviews.

Fontana and Frey note that “unstructured conversation, mere chitchat, listening to others without taking notes or trying to direct the conversation is also important to establish rapport and immerse oneself in the situation, while gathering a store of ‘tacit knowledge’ about the ... (subject) ... studied” (Fontana and Frey, 1994:371) Indeed, in many occasions both in Mexico and Colombia, these informal meetings were richer in information, and gained in depth and scope over formal interviews. Altheide and Johnson point that “bureaucratic settings have numerous occasions for what could be termed ‘bureaucratic tacit knowledge’. This includes understandings about written and verbal communications, ... (...) ... and language.” (Altheide and Johnson, 1994:493). Along those lines, these informal meetings gave me the opportunity to access information and further my understanding in areas that were not addressed during formal interviews.

This note withstanding, I made a serious effort to conduct as many formal interviews as it was possible from the different groups of actors described above in order to ensure objectivity and have the means to probe the information I obtained, as it will be discussed below. Interviews can be *structured*, *semi-structured* or *unstructured* (Fontana and Frey, 1994). Given the characteristics of the research required for this thesis, it was not relevant to conduct structured interviews, in which informants are asked to respond to a nearly identical set of questions, since this method does not allow sufficient leeway to adapt the interview to the informant's knowledge base and experience. It has been noted that unstructured interviews "vary widely, given their informal nature and the nature of the setting, and some eschew any preestablished set of techniques" (Douglas, 1985 in Fontana and Frey, 1994:371).

On the other hand, in many occasions the profile of the senior level interviewees and their tight schedules did not allow for informal interviewing, without structure or control. A compromise was therefore used between these two extremes, by devising *semi-structured* interviews, using an *outline checklist of questions* (Bernard, 1988) or *interview schedule* (Garson, 1996). The list of issues covered varied according to the informant and for this reason, each interview required major background information prior to the meeting. I put particular emphasis in trying to reduce ambiguity (Garson, 1976) given the complex and some times abstract subjects I was studying<sup>34</sup>, and in some cases I volunteered background information to assure that the respondent understood the context of the question (Garson, 1976). During interviews, I took notes, which I put onto computer as soon after the interview as possible (see appendix V for an example of an interview guide).

Colombia and Mexico are countries with little experience in open democratic processes and debate. Therefore, policy-making tends to be secretive and even information easily available in consolidated democracies can be considered sensitive. For this reason, as it has been stressed in this section, it was useful to have had previous work experience in these countries related to the health sector and to maintain close professional links with the actors in the field in both



countries. This was helpful in two ways. On the one hand, it allowed me to pursue participant observation and better understand the dynamics among the actors relevant to my study. On the other, it helped me establish links of trust with some of the actors I needed to interview, by trying to get to them through persons they trusted and respected.

A large number of issues that were dealt with during interviews were about power. Also, as will become evident throughout the study, information was one of the tools policy-makers and societal actors used to pursue their agendas. Furthermore, while in the case of Colombia many of the interviewees were not holding positions in public office any more; this was not the case in Mexico, where the health reform was still at its outset. Thus, the issue of confidentiality was a decisive one in opening the doors of high-ranking officials, and reassuring them that off-the-record comments would be respected, to put informant at ease. Even though a majority of the people interviewed decided to remain anonymous, their arguments were only used if I received confirmation of their account from another source. In the case of formal interviews, I sent back my notes to the interviewee for comments in order to affirm the accuracy of the story and perceptions. I classified the interviews by keeping a record of their date, and these dates were used throughout the case studies to trace back the information to the interviewee in case there was a need for further clarification.

To further verify the objectivity of the information gathered, and reduce the likelihood of misinterpretation, I resorted to systematic *triangulation* “a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation” (Stake, 1994: 241). However, this approach also served to identify and analyse the different ways by which the same phenomenon was perceived (Flick, 1992 in Stake, 1994) (see chapter 9 for a discussion on this matter). I was able to further probe the different accounts I recorded through the interaction with interviewees and other informants during the seminars I organised in each country as well as in academic fora in Mexico, the US and the UK. There, through group discussion, participants were invited to react to preliminary

versions of the case study, and I was given the opportunity to receive feedback (Garson, 1976) and refine my argument.

Given that a rather small group of actors was formally interviewed as explained above, it was not possible to provide the list of the 43 interviewees, since it would be very difficult to maintain the confidentiality of their accounts. Instead, a generic classification of interviewees – as well as other individuals with whom I held informal meetings - has been presented in this section. A more detailed list of the positions held by the persons contacted in each country is presented in appendices III and IV. Names of public figures only appear in the text and figures when referring to a fact that was official or known to the public.

#### **1.3.4 Field Work Organisation**

I completed the literature review and designed the study in London, from early 1996 to mid-1997. This was followed by preliminary fieldwork and primary document search in London, Mexico, Boston and Bogota, leading to the completion of the research proposal (upgrading document). Part of this thesis was conducted at the Centre for Population and Development Studies at the Harvard School of Public Health, where I reviewed primary and secondary data on Colombia's health reform. To conduct fieldwork I established residence in Mexico City and made field trips to conduct interviews in Bogota, starting in mid-1997 and ending in December 1999. Interviews also took place in London, Boston and Washington.

Soon after beginning fieldwork, I joined the Harvard School of Public Health as research associate and participated in a USAID-funded project entitled *Health Policy Process Project* as research director. I was responsible for co-ordinating this thesis in Chile, Mexico and Colombia, working with researchers in each of these countries. While I could not work on my own research during this project, there were many overlapping areas of interest, and through the project, I was able to interview many high-level officials in these countries, and gain access to the

health reform documents and policy evaluations at national and international levels.

While research of this collaborative nature inevitably involves input from a wide range of people, the research conception, design and analysis was my own and drew closely to my doctoral work. The fieldwork design, selection of informants and interview guidelines were my original work. I wrote the final report for this thesis synthesising my own findings and those of researchers in the different countries, and presenting a series of policy guidelines stemming from the findings. The data collected in fieldwork for the Harvard project fed into this thesis' case studies. Further fieldwork and analysis for the doctoral research was undertaken during the months after its completion, up until mid-2000.

At the final stage of my research, I was able to triangulate and get feedback on findings through a series of seminars sponsored by Harvard, USAID and the ODC in Mexico City, Boston and Washington, where I had the opportunity to discuss my analysis and receive useful comments from participants, as well as experts in the political economy of reforms. This helped me fine-tune my analysis and clarify my arguments in preparation for write-up.

#### **1.4 Caveats**

The main scope of the thesis was influenced and bounded by politics and the strategies that politicians, policy-makers and technocrats used in order to design and implement a health reform in Colombia and Mexico. This approach did not leave space to evaluate the policy content of the health reforms. The reforms were not assessed by the principles of equity, efficiency, access and quality or measured their impact on the population. However, these principles sometimes motivated the different players involved in the case studies. For example, business leaders in Mexico based their political stance on the reform along efficiency issues, and Colombian doctors argued that access and quality were being compromised by the reform. In both cases the thesis studied how these actors used their political leverage in order to influence the reform process, but at no time did

the research question their incentives or the extent to which their perceptions were reflected in outcomes.

The analytical framework used in the thesis was based on the following assumptions, which might limit its relevance in other countries. First, it assumes that the countries under study have a sufficiently developed state capacity based on the essential institutions present in a middle-income country in order to identify the independent variables (institutional context, policy process, change team) and enact a health reform with a political impact on the national public agenda. In that sense this framework might require adjustments for use in a low-income country with weak institutions.

Second, it assumes that international organisations played a limited role in influencing the political feasibility of the health care reform in Colombia and Mexico, and therefore the research did not look in detail to the micropolitics inside these organisations. The rationale behind this assumption is that international conditionality did not play a significant role in the country-level politics of health care reforms. Reforms were not a response to conditionality, they were influenced in their design by the ongoing debate in the international health policy community – reflected in the World Development Report of 1993.

Every attempt was made to be objective, by checking perceptions, and positions of interviewees against each other through probing, double-checking, and holding seminars to check the validity of the interpretations presented here. However it is inevitable that research of this kind is open to some level of interpretation and potential bias.

Among the possible sources of bias that may be reflected in the study, the following stand out: while testing the hypothesis of the strategies that change teams employed, the research had to rely heavily on accounts of the change teams in Colombia and Mexico, due to the fact that written accounts are seldom kept in Latin American countries, specially when reforms are being designed.

Another source of bias is related to the time frame of study. In the case of Colombia (1990 – 1994) the fieldwork was done after the health reform process had completed the formulation, legislation and the initial implementation stages; this enabled the research to have a clear view of the “big picture” when conducting the study. Also, the change team that led the reform had left office, due to the change of administration, when interviews were conducted. This situation probably allowed the interviewees to be more candid and volunteer richer information.

This ran in stark contrast to the case of Mexico (1995 – 1999), where the health reform was an ongoing process. This situation could have biased the study in different ways. In the first place, given that many of the events that were analysed were happening at the time the fieldwork was conducted, there was a real possibility of taking slow policy changes for no policy change at all. In second place there could be an inclusion of new actors who could try to affect the outcome of the reform by launching new political proposals. Also, as the change team was conducting and operating the political strategies to manoeuvre the reform through the public agenda, interviewees were considerably more cautious about their answers and comments than their Colombian counterparts.

Finally, the number and diversity of actors involved in a health reform process is large. However, not all have equal access to health reform formulation and implementation and only a few manage to effectively influence the reform process. Given that the rationale of this thesis is to look into the strategies and actors who have a tangible impact on the political feasibility of health reform – as well as the time and resource limitations of doctoral work – this thesis concentrated on those actors who had most potential to influence the health policy process. For the same reasons, the study concentrated on the national level, leaving the impact of sub-national and local level actors on the political feasibility of health reform – particularly at the implementation stage – as open agendas for further research.

### **1.5 Summary and Main Points**

This chapter reviewed current knowledge and research on health reforms generally, and noted the neglect of political analysis in the literature, which provided the rationale for looking at the political dimension of health policy reforms. Different approaches to the political economy of policy reform were analysed and critiqued in the light of their relevance for the analysis of the political dimension of health reforms. The resulting analytical framework that was designed for this thesis was presented, and its variables were described in the manner they were operationalised to undertake this thesis. The framework also presented the argument for the thesis in the form of two working hypotheses. The last sections of the chapter described in detail the methods used to conduct this research, with particular emphasis on case study analysis, the research process, and its organisation.

## Footnotes for Chapter 1

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<sup>1</sup> The first set of reforms aimed at the structural change of the economic sphere came to be referred to as *first generation reforms*; whereas the second set of reforms that followed, aimed at transforming the social sphere are called *second generation reforms*. See Graham and Grindle, 1999.

<sup>2</sup> Change team as a term, was used by Waterbury (1992) to describe the group of policy-makers who were in charge of structural reform. With a technocratic approach to policy-making, these groups' power stemmed from the direct support of the Executive. They were insulated from pressures stemming from interest groups and bureaucratic factions which had a stake in policy change as a strategy to maintain state autonomy in directing the policy change.

<sup>3</sup> See also Reich, 1994 and Foltz, 1995 for a critique on different approaches to the politics of the health policy process.

<sup>4</sup> For more on how globalization has induced policy decision-makers in different countries to embrace what Bjorkman and Altenstetter call the 'common middle ground', see Bjorkman and Altenstetter, 1997. Also see Marmor, 1997 for a critique on the oversimplification of health policy debate leading to a common international policy agenda.

<sup>5</sup> For recent literature on the subject, see among others Haynes and Broder, 1996; Pierson, 1996; Steinmo and Watts, 1995; Skocpol, 1995; Marmor, 1994; Moron, 1994. See also Marmor, 1983 for a collection of his seminal work on the politics of health, as well as an overview of the literature on the subject of the 1960's and 1970's.

<sup>6</sup> See Altenstetter and Bjorkman (eds), 1997 for recent works on the politics of health policy reform in Western and Eastern Europe, the Americas, and Israel.

<sup>7</sup> See Parsons, 1995 for the different theoretical approaches that have been used to analyse the politics of health.

<sup>8</sup> See Parsons, 1995 as above.

<sup>9</sup> Governments are defined in this thesis as the political entities that administer and regulate a nation or society. See Parsons, 1995 for a discussion on the role of governments.

<sup>10</sup> Policy-makers are defined by Nakamura and Smallwood as "the principal actors in policy formulation (...) people who occupy positions in the governmental arena that entitle them to authoritatively assign priorities and commit resources" Nakamura and Smallwood in Rist, 1994. :548). They will be referred to as government officials.

<sup>11</sup> For a discussion on the different roles attributed to the bureaucracy and the state see Suleiman, 1974.

<sup>12</sup> For a compilation of the relevant literature on the old approach to institutional analysis, see Eckstein and Apter, 1963.

<sup>13</sup> This particular aspect about the preferences of policy-makers stems from the literature on bureaucratic politics. See Downs, 1964; Schneider, 1991; and Geddes, 1994 among others.

<sup>14</sup> For instance, there is an ongoing debate about how to interpret the motivations of policy-makers when they implemented structural change. Many of the measures ran counter to the interests of important stake-holders who resisted the measures and in many cases withdrew their support for the government in office. When policies were accompanied by poverty alleviation programs, resources were allocated to the poor, who had serious difficulties in showing their political support, since they were not powerful or organised to do so (Nelson, 1990).

<sup>15</sup> The concept of 'capture' refers to the possibility of having powerful interest groups consolidate their influence on the state and thus bending public policy permanently in their favour. See Olson, 1982; Sandler, 1992.

<sup>16</sup> For a complete list of the variables used to assess the power of influence of an interest group, see Wilsford, 1995: 576.

<sup>17</sup> See Wildavsky, 1972; Lindblom, 1983; Rondinelli, 1984; and Korten, 1976 among others for definitions and characterisations of the policy process.

<sup>18</sup> See Parsons, 1995 for other definitions of the stages of a policy process.

<sup>19</sup> For an explanation of the rational choice model and its use in political science, see Riker, 1990.

<sup>20</sup> See Downs, 1967.

<sup>21</sup> The labelling of distinctive groups of policy makers or bureaucratic factions within the state has always been problematic. Schneider (1991) acknowledges that all policy makers are in essence part of the bureaucracy, but points to the fact that 'the bureaucracy' is not homogeneous, since different groups of bureaucrats have different preferences and degrees of power. Studying Mexico, Grindle (1977) makes a distinction between high ranking and mid-level officials within the

bureaucracy. In studying the role of the bureaucracy as a distinctive but integral part of the political system, Suleiman (1974) also distinguishes politicians from high ranking officials, but this distinction may prove deceptive when studying high ranking technical officials who engage in politics: the technocrats.

<sup>22</sup>Strong criticism has been raised about the deterministic emphasis on institutions. Other authors of the new institutionalist approach have argued that the constraints put by institutions are more flexible; and that in fact, transforming the institutional framework may be part of the policy-makers' political strategy (Rothstein, 1992).

<sup>23</sup>*Technocrats* were first defined as "individuals with a high level of specialised academic training which serves as a principal criterion on the basis of which they are selected to occupy key decision-making or advisory roles in large, complex organisations" (Collier, 1979: 403). Grindle defines them as public officials with extensive technical training, particularly in economics, who accumulate considerable political influence (Grindle, 1996). Dominguez refers to them as *technopols* to emphasise their combined use of highly technical skills and political manoeuvring (Dominguez, 1997). Centeno refers to them as *tecnocratas* and stresses that they combine the educational credentials of technical officials with the political access and acumen of politicians (Centeno, 1994).

<sup>24</sup>Technocracy as a social movement has its origins in the US during the depression in the early 1930's, when there was a growing belief that the application of the scientists' and engineers' scientific and technological principles to the social, political and economic spheres "could solve the problems that had so confounded politicians" (Parsons, 1995:266).

<sup>25</sup>Also see the concept of embedded autonomy in Evans (1992), whereby the state manages to maintain its autonomy in policy decision-making while at the same time establishing selective links with societal groups thus forming policy networks.

<sup>26</sup>For a compilation on the literature on the politics of economic adjustment, and a discussion of the use of change teams, see Haggard and Kaufman, 1992. However, governments have resorted to policy groups similar to change teams for a long time. Geddes (1994) sees similar characteristics in the 'executive teams' and 'pockets of efficiency' that the Brazilian government used in order to modernise the administration between the 1930's and the 1960's. Shneider (1991) also recognises the same features in the teams of policy makers in charge of the Brazilian industrial policy between the mid 1960's and the mid 1970's. Silva (1996) argues that even during the Frei and Allende administrations, technocrats played a role in Chilean politics, long before Pinochet's military regime. And Cepeda (1994) tracks the origins of Colombia's change team operating from the mid 1980's onwards, to the efforts to modernize the state in the 1960's.

<sup>27</sup>See Smith, 1993 for a discussion on elitist technocratic decision-making in Britain, and Suleiman, 1974 for the same topic in France's policy-making.

<sup>28</sup>She explains: "Governments rely on their officials to carry out reforms. Officials with a genuine commitment to their agencies and programs often deeply resent what they view as external attacks. More broadly, measures to streamline or privatise public enterprise, to tighten central economic agencies' control over budgets and expenditures, and to eliminate a wide variety of state controls and regulations over economic activity and convert others (...) from criteria within the discretion of state officers to quasi-automatic criteria or mechanisms all constitute a direct assault on the interests of many public employees" (Nelson, 1989:10).

<sup>29</sup>See Parsons, 1995 for other definitions of policy cycles and reform stages. Also see Rist, 1994.

<sup>30</sup>Part of this definition is borrowed from Immergut's definition of "veto points" Immergut (1992: 9) However, *policy node* was preferred to emphasise the fact that a reform may face equal chances of being vetoed – thus halted – or only having its policy content altered.

<sup>31</sup>For Hodder the written text is "an artefact, capable of transmission, manipulation, and alteration, (...) 'doing' different things contextually through time"(Hodder, 1994:393).

<sup>32</sup>Convenience sampling is also referred to as *haphazard* or *volunteer* sampling. See Goel, 1988.

<sup>33</sup>Goel (1988) notes that "effective use of (judgmental sampling) requires that the researcher have a wealth of political knowledge about the region being studied" (Goel, 1988:103).

<sup>34</sup>Garson points to the fact that "the most important variables in political science are abstractions: power, influence, trust, efficacy, loyalty, (...)" (Garson, 1976: 150). Most of these variables were of relevance to the thesis, putting an additional challenge on the interviews I undertook.



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**PART II**

**Colombia Case Study**

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## Colombia – Chronology of Events

Year(s)	Milestone
1940's	The ISS is created to provide services and pension to private formal sector workers. It is funded by employers and employees. Local health authorities are established.
1953 - 1958	Rojas Pinilla military regime. Peak to the ten year political warfare.
1958	The Liberal and Conservative parties sign the National Front Agreement.
1975	New health system organised around the MOH as head of sector, formally controlling social security institutions, private health providers and its own facilities; but it only controls its own.
1986 – 1990	<b>Barco Administration</b>
1986	First steps towards the decentralisation of health services. Efforts were to last until 1990's.
1987	The local health authorities begin to receive direct resources for health services as part of the decentralisation process.
1990	In addition to receiving funding, local authorities are put in charge of the provision of health services. The national level is to concentrate on policy guidelines and assistance.
1990- 1994	<b>Gaviria Administration</b>
Aug 1990	First stage of economic and state reforms including exchange rate regime, foreign trade, financial sector, taxation reform, housing policy reform and <b>labour reform</b> .
Jan/Jul 1991	National Constituent Assembly (ANC) is called to enact a new Constitution. The ANC mandates reform in <b>social security</b> , public services, education, planning, central bank and decentralisation. The new social security system was to be based on the principles of universality, solidarity and efficiency and was to cover the pensions and health jointly, as well as public and private sector entities.
Sep/Dec 1991	The Social Security Commission is created by the ANC with the objective of formulating the social security reform proposal. After several months, the Commission did not agree on a reform proposal.
Sep 1992	The Executive, through the Labour Minister, presents a social security reform project to Congress that does not include health. Congress rejects it and conditions the approval of the social security reform to the inclusion of the health reform.

<b>Dec 1992</b>	<p>The former DNP deputy director, Juan Luis Londono is appointed Minister of Health.</p> <p>Londono presents to Congress a partial health reform project (Empresas Solidarias de Salud) as a complement to the Executive's social security reform proposal. Congress rejects it once more and demands a comprehensive health reform.</p>
<b>Apr 1993</b>	<p>The Executive presents to Congress a social security project including a comprehensive health reform. From this moment onwards, the health change team takes pre-eminence in the health reform process.</p>
<b>Dec 23 1993</b>	<p>The social security reform is approved in Congress and ratified by the president. It included both health and pensions reforms.</p>
<b>Jan/Aug 1994</b>	<p>Expedition of Executive decrees ratifying the health reform's regulation package prepared by the health change team at the MOH</p>
<b>1994 - 1998</b>	<b>Samper Administration</b>
<b>Aug 1994</b>	<p>The change of administration puts in power a rival liberal faction that had opposed the health reform in the previous administration.</p> <p>This government is responsible for the implementation of the majority of reforms legislated during the Gaviria administration, including the health reform.</p>
<b>1994 -1995</b>	<p>Alonso Gomez is appointed Minister of Health.</p> <p>He attempts a counter reform by putting a halt to the reform's implementation and issuing Executive degrees to redress the resource allocation established by the health change team.</p>
<b>1995- 1996</b>	<p>Augusto Galan is appointed Minister of Health. He puts the health reform back on track by forcing President Samper to issue a degree overriding those issued by Gomez, and re-activating implementation.</p>

## **Chapter 2. Political Context**

### **2.1 Introduction**

During the 1990's, Colombia initiated a swift and in-depth health reform characterised by its technocratic approach. But the political context in which the reform took place empowered other actors, notably the legislators, who were able first to promote radical change, and then to influence its final form. The first stages of this reform process – incorporating the issue into the public agenda, legislating it and preparing implementation – was done in a surprisingly short period of time. But during this time, the reform's initially limited agenda for change was transformed into a more comprehensive project that reflected not only the technocratic position of the change team in charge of it, but also the positions of other actors involved in it. As a result, the reform contains multiple objectives expected to be accomplished simultaneously, such as equity and universal coverage, along with efficiency and cost containment.

This chapter presents a brief description of Colombia's institutional context from the perspective of the policy process. It focuses on the main arenas for policy-making and the actors in them, as they have been operating in recent years. A brief account of contemporary events in Colombian politics follows with a description of the formal and informal rules for political competition, interest representation and participation that structure the policy-making process. It then presents the arrival of the technocracy to power and its characteristics in chronological order, with particular emphasis on the Gaviria administration, when the health reform was initiated. The chapter concludes with a brief description of the Samper administration that was to follow Gaviria's, and in which the first stages of the health reform implementation evolved.

## **2.2 The Colombian Political System**

### **2.2.1 Division of Powers and Policy-Making**

Colombia is a Republic with a presidential government and division of powers – the Executive, the Legislative and the Judiciary. Formally, the Executive is in charge of implementing and enforcing the laws approved in Congress, the Legislature is in charge of formulating and issuing laws, and the Judiciary is responsible for solving non-armed conflicts between individuals, and between an individual and the state.

### **2.2.2 The Executive**

The Executive is headed by the president, elected with a four-year mandate, with no right to re-election. It is the most dynamic policy arena in Colombia's institutional context. It is the source of nearly all substantive policy formulation. Until the early 1990's, the majority of policy initiatives circumvented Congress, but the extraordinary prerogatives that allowed the Executive to do so were curtailed in the new 1991 Constitution. Nonetheless, the Executive still has extensive control over the legislative process, having the power to veto legislation passed by Congress, and to govern by decree, and it is the source of the majority of bills. In addition, the Executive has the authority to formulate and enforce the regulatory body of laws approved in Congress. This gives the Executive a second opportunity to shape the final outcome of a policy initiative. The Executive's leverage over Congress is further reinforced by the lack of technical capacity and political will of most congressmen to assume their formal role in policy-making (Acher, 1997).

Within the Executive, the president uses formal and informal mechanisms to reinforce the power vested in him and his control over the workings of the Executive branch. One of the key formal mechanisms is his prerogative to appoint the ministers, top and medium level government employees, and directors of

national decentralised agencies<sup>1</sup>. Among the informal mechanisms is the possibility of forming small teams of policy makers who remain very close to the president and whose combined technical and political abilities facilitate formulation and control over the implementation of the president's policy agenda.

In spite of the power imbalance between the Executive and the Legislative, the Legislative power remains an important veto power. The fragmentation of the political parties and the influence of the regions' rent-seeking behaviour in Congress has slowed down policy initiatives stemming from the Executive, since it is forced to lobby and secure the votes needed to pass legislation almost on an individual basis (Acher, 1997). The administration of President Gaviria was an exception to the rule. The social mandate for a thorough political and social reform, along with the political manoeuvring of the economic team that he empowered, were able to successfully pass through legislation a series of economic and social reforms. One of these reforms was the social security reform, along with its health component.

Within the Executive the highest formal decision-making bodies are the Council of Ministries – decisions of political content - and the National Council for Social and Economic Policy (CONPES) - decisions on social and economic matters. Both are chaired by the president. As a result of the state reform initiated in the early 1990's, the responsibilities and functions of the CONPES in the social policy area were modified, and these now include aspects such as decentralisation, joint financing of social services, social security and health care, among others (Decree 2132, 1992, Art. 26).

The National Planning Department (DNP) has the role of technical secretariat for this body, and in that role, it helps prepare all the white papers that are presented by the sector-specific ministries for analysis and discussion. While the existence and activities of this body are not enforced by law, it is here that all policy initiatives in the social sector are presented and discussed within the Executive, and law initiatives to be presented in Congress stem from it. Its power and

importance in the policy process depends entirely on the president's support of this decision-making body. Once the CONPES has defined the policy guidelines and the budget has been approved, ministries enjoy a high degree of autonomy in policy decision making.

A central factor undermining the Executive's capacity to implement its policy initiatives once they have been approved in Congress, is the high degree of circulation in top positions at the ministerial level. This is particularly conspicuous in the social sector ministries, since they are not seen as strategic as the economic sector ones, and therefore have their heads appointed on the basis of political *criteria* looking to maintain the government's coalition of support among party factions (Hartlyn,1994). The weaker the government in power, the higher the degree of circulation and, as a consequence, the higher level of state paralysis in policy-making.

### **2.2.3 The Legislature**

The Congress has two chambers: the Senate and the House of Representatives. It operates on the basis of specialised committees and plenary sessions. Although the latter is the final and highest decision-making level, most of the discussions, debates, and bargaining are carried out within the committees. With few exceptions, a committee's approval is simply sanctioned in plenary sessions.

Issuing a new law or reforming one is a long process taking up to a year to be discussed, negotiated, and eventually approved. When a bill is submitted to Congress it is turned over to a Commission or specialised committee in one of the congressional chambers. There, it is given priority among other bills according to the legislators' and the government's interests. It is during this period that the bill undergoes major changes. Political bargaining takes place between the Executive and the Congress, between congressional factions and between the latter and interest groups in society trying to influence the policy process at this stage. Once approved, the bill is turned to plenary sessions for further discussion and

negotiation, and eventual approval. Once approved in one chamber, the bill is sent to the other chamber to undergo a similar process.

Even though the Executive has considerable power in policy-making, the Congress maintains a strong veto power. However, its power resides largely in its reaction to the Executive's initiatives, since its fragmentation precludes it from being proactive in policy formulation and legislation - even along party lines. This is due to the difficulty of creating coalitions in support of policy issues, given that there is no party unity and members of Congress are not accountable for policy results at the national level, but for the particular benefits their local constituencies may obtain. The Executive is thus forced to build a congressional coalition for each policy initiative it submits for legislation, and the willingness and capability of the traditional parties to conform is each time uncertain (Archer, 1995 and 1997; Hoskin, 1997).

Finally, the persistent tension between the federal government and the regions is reflected in the competition for control over policy-making and public resource allocation between the Executive and Congress. While the Executive tries to impose policy guidelines on the regions on behalf of the national interest, Colombia's regions use Congress to influence policy-making in particular benefit and often resort to rent-seeking behaviour. This has created such political incentives that legislators tend to condition their vote in favour of federal level policy to perks and benefits for their regional and local constituencies (Hartlyn, 1988; 1994, Archer, 1995; 1997).

#### **2.2.4 The Judiciary**

The Judicial branch of power is formed by four bodies: The Supreme Court, the Constitutional Court, the State Council and the General Prosecutor's Office. Following the political reforms brought about by the new Constitution in 1991, the Judiciary has tried to recover ground in the balance of powers with the other two branches of power. Although still facing the challenges of modernising and

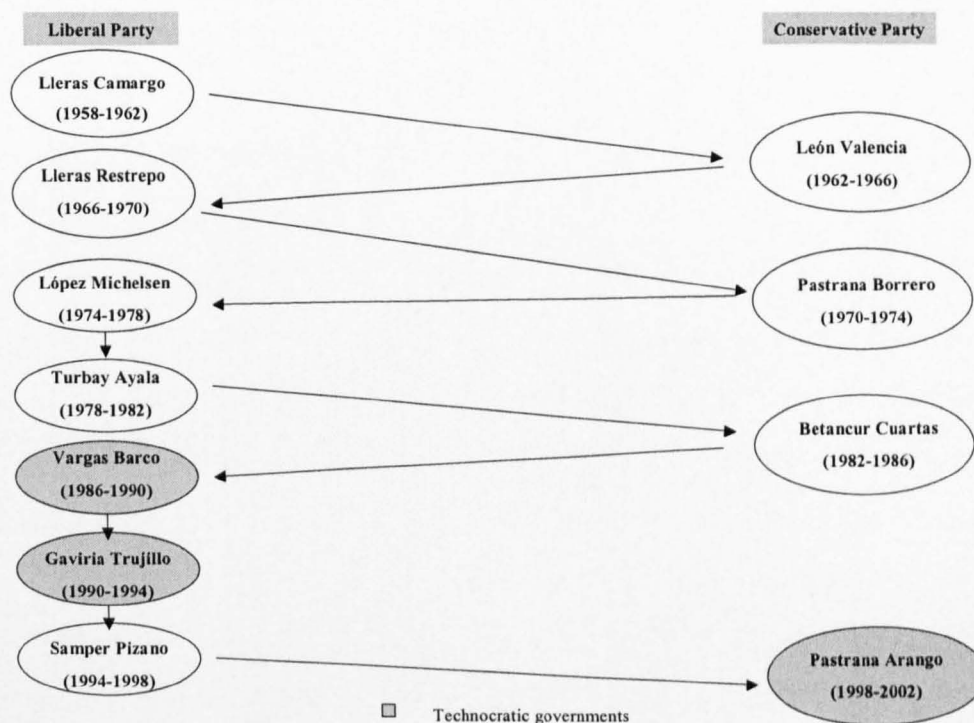


speeding the process of administration of justice and de-politicising its configuration and dynamics, it has made progress in its role as a check and balance by pursuing cases protecting citizen's rights *vis-à-vis* the Executive and in constitutional legislation. Issues stemming from the health reform's new law have been at the centre of such an institutional power struggle (Palacios, 1995).

### **2.2.5 Structuring Politics: The National Front (1958 – 1986)**

During the 1940's and 1950's Colombia suffered a period of violence between adherents of the two traditional parties, the Liberal and the Conservative, which left more than 200,000 deaths and the imposition, in 1953, of a military regime. In order to restore civilian rule and stop the violence, both parties established a partisan accord in 1958 called the National Front. This accord introduced the power-sharing rules by which the parties agreed to rotate the presidency by having only one party nominate a presidential candidate in four-year turns. As a result, in spite the fact that regular elections were held, party alternance in power was not a reflection of voters' preference – since there was only one presidential candidate to vote for -, but the result of this agreement. Thus, as it can be seen in figure (2.1), a “pendulum” pattern<sup>2</sup> emerged and was to last until the Barco administration in 1986.

Figure 2.1: Party Rotation After the National Front Accord



The agreement provided for positions at all levels of government – with the exception of the Presidency -, as well as the Congress, to be shared among the parties on an equal basis, regardless of electoral results. This power-sharing commitment was furthered by establishing a requirement of a two-thirds majority vote in Congress for the approval of a law initiative.

The National Front achieved its short-term goals by restoring civilian rule in 1958, and ending inter-party violence in the following decade. However, it generated a series of side effects for politics and policy-making in Colombia. For instance it created barriers for the participation of other parties and political groups, limiting not only the incentives for competition, but also political participation and interest representation<sup>3</sup>. The instances for institutional competition among societal groups with different ideological and political positions were rendered ineffective, and this

created the conditions for the re-emergence of violence, although this time not among the traditional parties, but from societal groups excluded from political competition against the state. Both the FARC and the ELN, the two strongest guerrilla groups, emerged in the mid 1960's and gained strength in the following decades.

The need for a two-thirds majority in a bipartisan Congress generated the incentives for coalition-building and voting on an individual basis, instead of voting and negotiation along party lines. Power-sharing brought the role of the opposition to an end, and policy debate among political parties was merely rhetoric. Legislators tried to secure re-election not by studying and debating policy initiatives, but by conditioning their vote to the allocation of public resources and benefits to their regional constituencies and control over a certain number of government posts with the same purpose. This, in turn, promoted the emergence of regional and local leaders whose careers were not based on their ideological or programmatic coincidence with the traditional parties but on their ability to control a constituency by obtaining public resources and benefits for it. The political elite at the national level reacted by centralising decision-making at the party conventions, where national party leaders took the important decisions and elected the presidential candidate.

A constitutional reform in 1986 formally sought to limit the life-span of the National Front accord to 1974, at which time political competition was to be reintroduced in the Executive and Legislative branches, as well as in regional and local elections. It also reduced the number of issues requiring a two-thirds majority in Congress for legislation. But the two-party rotation for the Presidency, even if formally terminated, was maintained until 1978, and the distribution of government posts among the two parties on an equal basis was to continue, with one short-lived exception<sup>4</sup>, until 1986 (Hartlyn, 1988; Leal, 1989; Dix, 1987; Kline, 1995).

The Barco administration (1986-1990), was the first single-party government since the 1940's, as a result of the Conservative party's refusal to participate in a coalition

government that reflected electoral results – which gave the Conservatives only 35% of government positions, instead of automatically assigning it half of the government's posts. This was seen as the end of the coalition governments established by the National Front accord – which had formally ended in 1974 -, and thus as an opportunity for the return of more disciplined parties with clear ideological profiles and separate policy platforms resulting from the newly invigorated need for party competition (Hartlyn, 1988; Bushnell, 1993; Kline, 1995; Dix, 1989; Cepeda, 1994; Hoskin, 1990).

## **2.3 The Actors**

### **2.3.1 Political Parties**

The party system in Colombia is characterised by the predominance of two traditional parties that emerged in the mid-19th century - Liberal and Conservative. They have shared 90% of votes in presidential and congressional elections throughout the 20<sup>th</sup> Century. The power-sharing agreement they arrived at in the late 1950's, and the influence of Colombia's regions in legislative politics led to their fragmentation and de-based them of ideological cohesiveness.

During the last 40 years, a few short-lived movements have been able to control a little over 10% of the votes; in most cases they have been either a coalition of small parties or a strayed fraction of the two traditional parties.

Only two political movements formed outside the realm of the traditional parties were able to accumulate a significant number of votes to have seats in Congress, albeit temporarily. These were the Patriotic Union (UP), the political arm of a guerrilla group (FARC), and the Democratic Alliance, created by a demobilised guerrilla group (M-19) and led by one of its former leaders, Navarro. The Democratic Alliance obtained a third of the total votes during the 1990 elections - establishing itself even above the Conservative party - and winning a dozen seats in Congress. This electoral mandate forced the government to include the movement in

the Executive's cabinet, and Navarro was appointed Minister of Health during the Gaviria administration – at the time when the health reform started to be discussed. In the 1994 elections, the UP lost all its congressional seats and presented no presidential candidate. The M-19's Democratic Alliance obtained only one seat in Congress and less than 5% of voters' preferences for president.

### **2.3.2 Business**

In the absence of party representation, powerful societal groups have resorted to other types of organisations seeking to influence policy decision-making by directly interacting with the Executive. Their access to decision makers has been favoured by the political parties' lack of control as state-society intermediaries. The level of influence of these groups has increased during weak governments that have had to bring them close to policy decision-making in order to maintain their coalitions of political support. Instead, strong governments have been able to substitute the lack of party ideology by resisting interest-group pressure and appointing like-minded individuals to their cabinet positions (Hartlyn, 1989)<sup>5</sup>.

Public officials seeking to control policy-making are not the only obstacle to these societal groups' access to policy-making. They stem more from the nature of the groups themselves, which are heterogeneous, fragmented and have unequal access to the arenas of policy-making. In the case of producer associations, which count among the most powerful groups, they lack member representation and in some cases are unable to have their membership abide by agreements reached with government. Yet they remain influential groups, in clear distinction with consumer associations, which have found access to policy decision-making more arduous.

### **2.3.3 Labour**

Only 7% of the work force in Colombia is unionised, since half the economy is made up of small enterprises mostly in the informal economy. While it can be argued that the union movement is fragmented and weak in the private sector, the

same cannot be said of public sector unions, and particularly those related to the provision of social services. The latter have a higher degree of influence on the Executive, members of Congress and the media through their participation in Congressional Commissions – to which they may be formally invited; as well as in public debates and other negotiation arenas. But their main means of exerting influence over policy decision-making is their political mobilisation capacity, notably through strikes, to press for interests, such as wages, employment benefits and job security.

The most powerful labour organisation is the public school teachers' union (FECODE), which currently has approximately 250,000 members, strong leadership with high representation, and is very disciplined. The health-sector workers' union is much less important in terms of its influence in the policy-making process. As opposed to the teachers' union, the health labour movement is fragmented with separate unions for hospital workers, medical doctors, nurses, and others; and their political mobilisation tends to be isolated.

Outside the social sector, unions with particular strength are those in strategic sectors, notably the oil workers' union of Ecopetrol. Other examples are those of truckers and public inter-urban transport, among others. Finally, there are a few umbrella organisations, which group together important unions and have strong influence, such as the Central Unitary Union (CUT), which represents most labour unions; or the Public-Sector Workers' Union. These unions - particularly the CUT - play an important role in the annual definition of the minimum wage, which takes place in a government-business-labour committee.

#### **2.3.4 Bureaucracy**

The state bureaucracy in Colombia was divided into three levels: high, middle and low level. High-level bureaucrats or policy-makers do not promote their interests through unions or any other type of formal organisation, they pursue their careers and protected their interests through the informal networks with other policy-

makers. Mid-level officials sought to promote their interests by demonstrating the loyalty to their boss. Only low-level public employees joined state workers' unions in order to pursue and protect their interests by means of collective action (Cepeda, 1990).

The president appoints all cabinet ministers and vice-ministers, however, ministers have a say in the nomination of some of their close collaborators. Each of these, would in turn name his/her work team, and loyalty and trust are prioritised over expertise and performance (Grindle, 1977). The lack of an institutionalised civil service in Colombia, and the change of administration every four years has brought a massive renovation of personnel within the public sector. The incentives to build a career in the public sector on a specific field is not very feasible due to the shifts within government and to policy think tanks. The higher the rank of the bureaucratic level, the higher the degree of circulation.

Given the lack of institutional mechanisms for a meritocratic career, policy-makers are dependent on their personal network and the factions within their political parties to ensure the continuity of their careers. When high level bureaucrats leave office, they are sometimes offered a position in one of Colombia's think tanks, like *Fedesarrollo*, in order to wait for the next administration to take office or obtain a post through one of their parties faction. This revolving door phenomenon between government and think tanks has created a certain level of job security for senior officials. It has also created a type of overlooking body, with the technical skills, able to monitor policy decisions by the current government, similar to that of a shadow cabinet.

### **2.3.5 Civil Society**

Aside from business and labour organisations, other societal groups outside the state have been able to influence policy-making. Among these, think tanks (*Fedesarrollo*); the academia; foundations (FES, Corona Foundation); the mass media and individual opinion leaders, such as former presidents and individual

journalists. These groups have increased their mobilisation and influence since the 1970s and, to a certain extent, have filled the political space left by political parties. They have been the most consistent interlocutors of the government, analysing, doing follow-up and criticising public policy decisions. Their power has depended on their level of organisation, their resources, the importance of the sector they represent and their analytical capacity (Sánchez, 1989).

They have sought - and in most cases obtained - access to policy-making through informal and semi-institutionalised channels. Their most visible and direct access to policy-making was through congressional commissions, and by having some of their members win congressional seats. But in most cases, they resorted to their analytical authority and knowledge and information on particular policy issues in order to exert their power of influence in different policy arenas within the political system. While Congress was the most visible of these arenas, they prioritised influencing the Executive, given its importance in the policy-making process.

There were clear informal channels among these societal groups and high-level decision-makers in the Executive - including the president and the ministers - due to the revolving door between government posts and positions in organisations such as producer associations, the academia, think tanks and other private foundations. Formally, there were frequent institutional forums in which government and pressure groups interacted, but their direct influence over policy-making happened through informal personal contacts with policy-makers away from public scrutiny. However, these groups resorted to the mass media and to the courts to present their cases when these channels of access failed (Bushnel, 1993; Hoskin, 1997).



## 2.4 Technocracy in Power

### 2.4.1 Origins

As a response to the policy immobility generated by the political arrangement described above, in 1968, the government of President Lleras Restrepo promoted a constitutional amendment to strengthen the Executive's power, with particular emphasis on the president's control over economic policy (Hartlyn, 1994; Archer, 1997). In order to increase the Executive's command over the economic sector, monetary and fiscal policies were centralised and taken away from congressional intervention. Also, control over the budget and foreign trade was re-taken by the Executive, requiring the approval of the Finance Ministry and the DNP, instead of that of Congress.

Heavily influenced by international trends – promoted by multilateral development agencies – the Lleras Restrepo administration (1966 - 1970) strengthened state intervention and the centralisation of policy decision-making and planning (Cepeda Ulloa, 1980). It also aimed to professionalise the bureaucracy in key areas of government, as well as of the policy-making process, by basing it on technical assessments of policy and public investment projects. This prompted the training and recruitment of a technical work force in decision-making positions within the state that was to be the precursor of the technocratic teams of the 1980's and 1990's.

Two central policy-making bodies were strengthened along these lines within the Executive. The Economic and Social National Council (CONPES), chaired by the president, which was to become the highest level of policy decision-making and the National Planning Department (DNP), which was put in charge of the national development plan and, along with the Finance Ministry, of the public annual budget. All decisions related to the national budget – including budget allocations to the different ministries and national agencies – were put under the joint responsibility of the Finance Ministry and the National Planning Department.

For the sake of improving and rationalising policy-making, a particular effort was made to isolate these two government agencies from party politics and the patronage network that had taken control of all realms of the political system. The positions of both Finance Minister and Director of the National Planning Department were no longer subject to political bargaining and they were assigned to technical professionals who were close to the president. The assignment of these two policy-makers tended to be stable and the high level of circulation that permeated the other ministries was avoided.

The recruitment of policy-makers for both agencies was made from highly trained technical professionals, mostly economists, who did not have previous political experience. This effort started a trend in which the government became the principal recruiter of economists with graduate studies in important universities in the United States and in Europe for the following thirty years (Cepeda, 1994). This strategy played an important part in Colombia's economic performance during that same period of time <sup>6</sup>, since it successfully limited the political use of economic policy and provided the state with the capacity to manage the growing complexity of economic policy. As a result, the Ministry of Finance, the National Planning Department, along with the Central Bank and the Office of the President, became the source and support of state reform and policy change initiatives in the following decades.

The expansion of the central level's control over national policy-making was another feature of this effort to regain control of policy-making. More than 60 central agencies were created during the 1960's and 1970's (Bird, 1984) putting under central control policy responsibilities previously in the hands of regional and local governments, such as water supply and sewage, health and education. Simultaneously, the government created regional and field offices for these agencies under central control and with no formal link to regional and local authorities, whose functions and responsibilities were overtaken.

As a consequence of this centralisation process, in the early 1970's health and education became the exclusive responsibility of the federal government – in what was called the “nationalisation” of health and education. From then on, teachers and health workers became civil servants under the jurisdiction of the national level<sup>7</sup>. Tax revenue resources for primary education and health services were allocated to the different departments, but it was the regional offices of the ministries of health and education that received and managed such resources, with no participation by regional authorities.

#### **2.4.2 The Arrival of Technocracy to Power:**

##### **The Barco Administration (1986 –1990)**

The arrival of President Barco to power in 1986 marked a turning point in politics and policy-making in Colombia. His profile was different from that of his predecessors in that he had a highly technical background as well as experience in politics. He also brought with him the experience obtained by his exposure to the international arena. He had occupied technical ministries such as the public works and agriculture ministries and had broad international experience in Washington as director for Colombia in the World Bank and in London as ambassador. He also had an active participation in politics: he was a member of Congress for more than twenty years and had his political base outside the capital. He was also Mayor of Bogotá. He had studied engineering in Colombia and post-graduate studies at MIT.

His administration attempted to change the political rules of the game and introduced major state and economic reforms. Although these reform efforts were not to be consolidated during his administration, they set the basis for the period of major reforms that were to follow in the 1990's in the economic and social sectors. He considered technical expertise as a condition for state performance, and thus was the first to empower public officials with high technical skills and entrust them with the formulation and implementation of the public agenda in

several fields. He also systematically attempted to bridge the gap between this new breed of policy-makers and politicians.

President Barco tried to depart from the traditional coalition government arrangement by presenting in his candidacy a liberal platform with little space for the conservative agenda – a stark difference from the previous conservative government that incorporated the agenda and the members of the Liberal party in a traditional coalition government. The resulting party unity, along with the weakness and the lack of support for the departing conservative government<sup>8</sup>, gave the Liberal party a clear majority (58%, *vis-à-vis* the Conservative party, which obtained 34% of the votes).

But party unity for electoral purposes was not sustained once the Liberal party was in power. The government received serious criticism from its own ranks, particularly congressmen eager to pursue their political careers by differentiating themselves and/or their factions, instead of by abiding by party discipline. But in spite of politicians' resistance from within and outside the party, President Barco pursued his efforts to modernise the state. For that purpose he empowered a group of technocrats<sup>9</sup> whose power depended exclusively on his political support. They occupied the core positions in government – Finance, Planning, Central Bank and the Office of the President – and became the government's spokesmen, particularly in Congress. Their technical apolitical discourse and their lack of experience in political manoeuvring created serious tension between the Executive and Congress, and President Barco had to reshuffle his cabinet in order to protect his technocratic team.

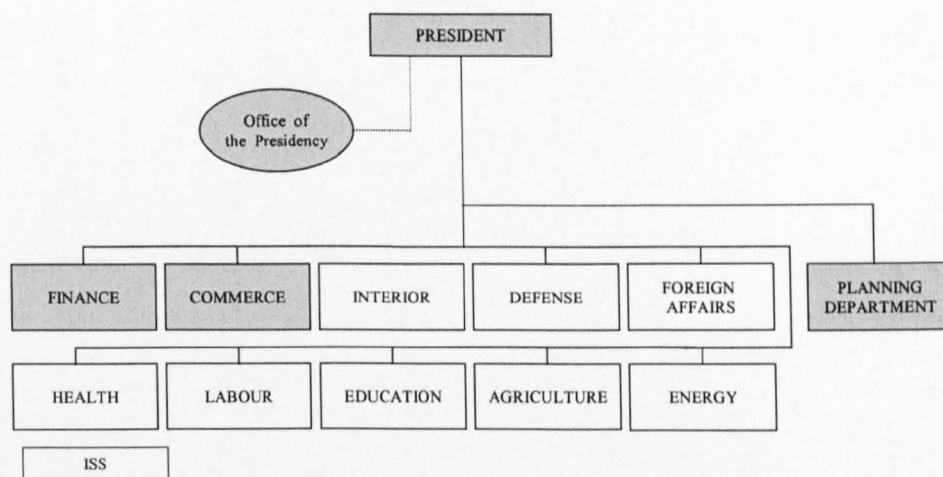
In spite of the regions' control over Congress and the prevailing effects of the National Front accord, the Barco administration managed to introduce key state reforms. It legislated and implemented the first major decentralisation effort, which devolved the management responsibility of a series of public goods and services to local governments. Such was the case of water and sewerage, local infrastructure, urban and rural electricity, rural extension services, infrastructure for

primary education and health, urban public services and urban planning, among others. This was accompanied by the reallocation of resources in the form of intergovernmental transfers and an increase of the share of the value-added tax to be transferred directly to municipal governments with 45 % earmarked for social services and infrastructure.

In the political arena, it passed a constitutional amendment by which mayors were to be elected by popular vote in local elections, and were to assume executive responsibilities as heads of local governments. This endowed local governments with greater autonomy and limited the centre's influence over local policy-making<sup>10</sup>. Other measures aimed at enhancing community participation were the establishment of the practice of referendums for decision-making on key issues, the direct election of local administrative boards - community bodies with delegated executive functions – as well as other measures.

In the economic arena, the Barco administration introduced what was called the *Strategy for Modernisation and Internationalisation of the Economy*. Since its approval was achieved during the last year of the administration, only a few measures were implemented – such as lowering import tariffs - but this effort set in motion Colombia's economic reform during the following administration. Of particular relevance was the fact that for the first time, this reform was conducted by the small group of technocratic policy-makers close to Barco, thus forming an economic change team<sup>11</sup>. The economic reform's policy formulation – the white paper – as well as the first steps towards implementation, were put in the hands of this team made up of a few ministers and presidential advisors with highly technical skills, and who had been part of the Barco government since his arrival in power. Figure (2.2) shows the location of the economic team in the Gaviria administration.

**Figure 2.2: Government's Economic Team\***  
(1990 – 1994)



\*Indicative, non comprehensive diagram

### **2.4.3 The Consolidation of Technocracy in Power: The Gaviria Administration (1990 – 1994)**

In 1990, César Gaviria became the youngest president of Colombia at the age of 43. He had been the campaign co-ordinator for the Liberal party's presidential candidate, Luis Carlos Galán, who was assassinated by the drug cartels when he was the most likely winner of the presidential elections. Gaviria counted on the support of former President Barco, in whose administration he was Chief of Staff for several years until joining Galán's campaign. Gaviria and his close team were economists with post-graduate degrees mostly obtained abroad. Nonetheless, he had enough political manoeuvring skills to manage to secure the support of former Galán followers who were also in favour of major reform, as well as that of the traditional leaders of the Liberal party.

Gaviria formed the first echelons of his governments with the youngest generation of highly technical professionals with little previous experience in politics: their average age was in the early thirties. Only a few members of his cabinet stemmed from the ranks of the traditional party elite. He appointed the ex-guerrilla leader of the former M-19 group – now Democratic Alliance movement – Navarro, as Health Minister<sup>12</sup>. Gaviria also appointed civilians to posts historically assigned to the military, such as Minister of Defence, and the DAS director.

The Gaviria administration set out to implement a radical reform in Colombia's institutional context, the state and the economy. The economic reform was based on market liberalisation, privatisation, and the modernisation and internationalisation of the economy. This was not set in motion as a response to a perceived acute economic crisis. Instead, it sought to increase economic growth through economic liberalisation with particular emphasis on trade and labour reforms.

In spite of the emphasis on the technical aspects of their policy initiatives, President Gaviria and his economic team were aware of the political implications of their reform agenda. According to Montenegro, the DNP director, their reform agenda was aimed at trying to dismantle the model of elitist pluralism that had led to the state's capture by important business groups. One that had resulted in public policies responding to particular interests, high protectionism, state inefficiency, and its inability to procure policy change (Montenegro, 1997). Hommes, the Finance Minister, who had an open confrontation with one of the most powerful economic groups in the country – Grupo Santodomingo – backed this position.

The economic change team's liberalisation initiative counted on the backing of multilateral agencies, such as the World Bank, which had been promoting it for the last decade. Within Colombia, a coalition of strong actors supported trade liberalisation. These included the export sector, politicians, technocrats and some producer groups; as well as some universities and think tanks with high credibility in public opinion which counted among its members a significant number of former policy-makers who still had political influence.

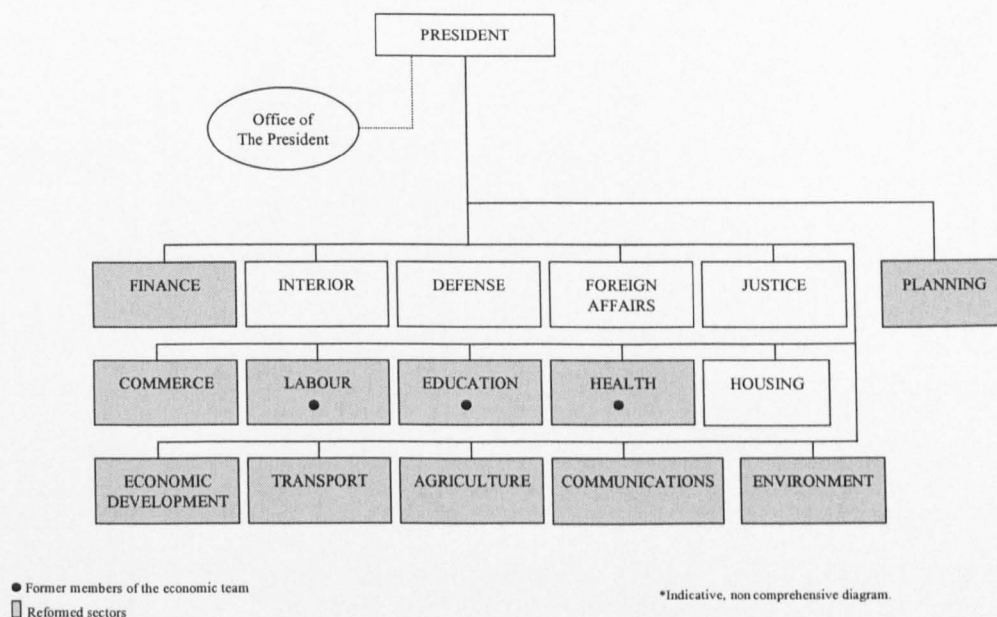
The government presented an initial package of in-depth economic reforms – designed by its economic team – and had them approved in Congress<sup>13</sup>. This set of laws was completed with a series of policy initiatives that were approved by presidential decree. A particularly controversial one was the labour reform – to which President Gaviria had given priority – and which was prepared by his team before taking office in order to have it ready to submit to Congress (Urrutia, 1996). Congress had a tradition of impeding any initiative that could diminish labour rights or go against organised labour's interests, but the academia played an important role in showing levels of unemployment and job instability as a direct result of the existing labour legislation. Thus, the labour reform was approved in spite of organised labour's opposition.

The rather swift approval of the labour law can also be attributed to the fact that the debate around the organisation of the National Constituent Assembly (ANC) was taking place simultaneously, taking public attention away from these controversial reforms. Issues such as the drug cartel crisis and the guerrilla movement further diverted public attention. Opinion polls at the time showed that the electorate backed the Executive's policy and the Executive moved on with its economic liberalisation agenda (Urrutia, 1996).

As had been the case during the Barco administration, the group working on these reforms was small and relatively isolated from bureaucratic pressure. The economic change team started formulating these policy initiatives before President Gaviria took office, thus securing the possibility of presenting them for legislation in due time. Figure (2.3) shows the sectors that were reformed during the Gaviria administration. The small dots show the presence of economic team members who were appointed to positions within these sectors to lead their reform process.



**Figure 2.3: Colombia State Reform  
(1990 – 1994)\***



During the process of policy formulation that continued once Gaviria had taken office, the strongest opposition to Gaviria's reform agenda stemmed from within the Executive. Particularly from the Minister of Economic Development, Ernesto Samper – a Liberal Party member, but from an opposing faction, who had joined Gaviria's campaign and was to succeed him as president. He led another group of economists<sup>14</sup> who although not being against economic liberalisation in principle, criticised the pace and depth at which Gaviria's economic change team was planning it. This prompted a long and serious struggle between the two government factions, which eventually needed the direct arbitration of the president.

The economic change team saw the relevance of the social sector as a key investment in the country's human capital, but saw its institutional organisation as a welfare-style apparatus which was extremely politicised. They therefore thought that new mechanisms and institutional changes should be introduced in order to promote efficiency through targeting, decentralisation, demand subsidies and the

involvement of the private sector in the provision of services. Budgetary allocations for the social sector during this period were not diminished, but actual expenditure and implementation were delayed in part by the requirements of the new Constitution for institutional change (Consejería Presidencial para la Política Social, 1994).

#### **2.4.4 The 1991 National Constituent Assembly (ANC)**

In 1991, in the midst of the Gaviria administration, the National Constituent Assembly (ANC) was elected and started to operate. Its mandate was to draft a new Constitution that was to respond to the political needs and aspirations of Colombian society in the 1990's<sup>15</sup>. After a year of work, the ANC issued a comprehensive new Constitution that involved a radical institutional reform as well as reforms in the political, economic and social spheres. The institutional reform included the reform of the Judicial and Legislative branches.

The ANC aimed to establish a real balance of powers between the Congress and the Executive. It focused on reducing patronage and improving the transparency of the political process, as well as diminishing vote buying. For this purpose, it mandated the dismissal of Congress in August 1991 and new congressional elections later on that same year. Other measures included the democratic election of departmental governors, new measures geared at increasing political participation, and community participation in local affairs, as well as an electoral reform.

In the social and economic spheres, the package of policy reforms that were presented by the Gaviria government to Congress was ratified by the ANC, and a new series of policy reforms were added to them by the ANC<sup>16</sup>. For the majority of these policy reforms, the ANC only presented a general framework and, in some cases, a series of guiding principles. This left policy formulation in the hands of the Executive and Congress, granting both branches of power a wide margin for manoeuvre to define the final content and direction of these reform initiatives. The

new Constitution gave the Executive one year to prepare the reform initiatives and the Legislature one congressional period to debate them. This contributed to speeding up the reform process in several policy areas, including health.

#### **2.4.5 Policy-Making after the ANC: The Remaining Structural Reforms**

Responding to the ANC's schedule requirements, and following its own style of policy-making, the Gavia administration set out to prepare the series of policy initiatives to be presented in Congress in areas such as social security, education, transportation, sub-national governments regime, decentralisation, the budgetary process, and others. For this purpose, the government formed a series of change teams integrated by officials from the relevant ministries according to the policy initiative. For all policy proposals being prepared, the Finance Ministry and the National Planning Department headed the policy formulation process. Officials from the Ministries of Health and Labour formed the change team for the social security reform.

This strategy was successful in streamlining the decision-making process within the Executive, and made it more expeditious. However, in spite of the ANC's mandate, the legislation process to approve this package of policy proposals proved to be much slower than the approval of the first package of reforms presented to Congress before the ANC. Given that Congress had gained leverage, the Executive's leeway to formulate and legislate policy initiatives without consensus building diminished. This forced the Executive's change teams to use more open political strategies, "market" their policy proposals to legislators and assist members of Congress in charge of presenting the reform bills.

Factionalism and fragmentation remained virtually the same after the ANC. The fragile unity of the newly emerged political forces – stemming from the demobilised guerrilla groups – was broken. The influence of unions, interest groups, and sub-national governments increased. As a result, when the Executive sought the approval of a policy initiative in Congress, it had to bargain in most cases

on an individual basis with each legislator (Shugart, 1992). However, the prevailing intra-party factional politics of the traditional parties helped the Gaviria government secure the needed number of votes for the approval of its policy initiatives, since it could compensate the loss of votes of its own party with a number of votes from the Conservative party – particularly from a new technocratic and pro-modernisation faction, led by future President Pastrana.

Also as a result of the new Constitution, society turned its attention to the policies being discussed in Congress, thus submitting the process to a higher degree of public scrutiny. The politicisation of the policy debate was further increased by the weakening of the Gaviria government, who had lost society's original support in bringing about radical reform, and was facing the lowest levels of popularity due to a perceived mismanagement of the drug traffic issue and an energy crisis. This empowered societal actors such as the unions, which found effective means to influence decision-making and to veto policies counter to their interests<sup>17</sup>, in stark contrast to their low profile during the expeditious approval of the labour reform.

The first generation reforms – related to the economic adjustment – were formulated and legislated during Gaviria's first years in office, when he counted on a strong popular mandate for reforming the state and had enough time to implement and consolidate policy changes. The social reforms – or second generation reforms – were legislated during the second period of Gaviria's government, with no time left for their implementation, and during a particular time in which Congress enjoyed recently acquired leverage due to the new Constitution. This not only reflected the complex preparation for implementation this set of policies required, but the fact that their processes of formulation and legislation were more lengthy and controversial than those of the first set of reforms. Since it cannot be argued that the first generation reforms were less controversial, it may be concluded that the determinant factor was the political context in which both groups of reforms were legislated.

#### 2.4.6 Technocracy Delimited: The Samper Administration (1994 – 1998)

In August 1994, the Liberal Party's candidate, Ernesto Samper, was elected president after winning slightly more than 1% over his rival in second-round elections – having lost the first round. This weak mandate, and the drug money political scandal that soon besieged his government<sup>18</sup>, forced Samper back to old power-sharing politics. Also following his more political profile, he focused policy-making on the construction and maintenance of a large and heterogeneous coalition of political support – with the marked presence of the traditional political leadership. As a result, his government's composition reflected the 50%-50% arrangement similar to the coalition governments of the National Front accord, and budget allocations and public project implementation followed clear *criteria* of political survival<sup>19</sup>. He did, however, maintain the technocratic profile of the economic ministries, where he appointed two respected economists – Perry and Ocampo – Finance Minister and DNP director respectively.

Although stemming from the Liberal party too, the Samper administration represented a departure in ideological stand from the preceding Barco and Gaviria administrations. During his term as Economic Minister under the Gaviria administration, Samper headed – along with Finance Minister Ocampo, who was then Agriculture Minister – the most visible resistance to President Gaviria's policy agenda stemming from within the Executive. At the time, his faction opposed the radical liberalisation measures promoted by Gaviria's economic team on the grounds that the country could not undergo policy and institutional change at such a speed, and that the reforms' content did not reflect society's participation. Therefore, during his administration, he sought to slow down the reform process and, in a great departure from their top-down technocratic process, to search for consensus building around policy initiatives. As a result, interest groups such as unions, professional associations and the bureaucracy, recuperated the leverage they had lost in previous administrations, and regained access to policy decision-making.

President Samper's economic team did not resemble the small, isolated and powerful group of technocrats who worked close to President Gaviria. Instead, although the Minister of Finance and the Planning Director still held the most influential positions, their leeway for manoeuvre was severely limited by the participation of other cabinet ministers – as well as many presidential advisors - who were given voice and veto power in cabinet meetings. This made policy-making slow and even erratic, as was the case of the health reform's initial implementation process.

It was in this political context that the reforms formulated and legislated during the second period of the Gaviria administration were implemented. These included, among others, decentralisation, education, social security and health. Furthermore, President Samper's visible opposition to some of these reform initiatives during the previous administration was not only a clear precedent of his intention to modify them during their implementation, but also sent confusing signals about his administration's support for them. This had serious repercussions in both the speed and scope of these reforms, with health being no exception. However, while reforms such as decentralisation and trade liberalisation were drastically modified and in some cases halted – with some attempts at reverting laws that had already been approved in Congress – the Samper government moved ahead with the social sector reforms – including health – with the expectation of gaining political dividends by showing an emphasis on the social sector over economics.

## **2.5 Summary and Main Points**

This chapter has described the main characteristics of the political context in which the Colombian health reform was initiated in the early nineties. In Colombia, the Executive has important policy-making powers. While some policy initiatives need to be approved by Congress, many others remain the domains of the Executive. This situation, even when modified by the ANC, played a key role in the state's ability to bring about policy change. This ability was reinforced by

the creation, started in the late 1980's, of pockets of efficiency within government agencies – particularly in the economic institutions such as the Central Bank, the Ministry of Finance and the National Planning Department. Groups of technocrats stemming from these institutions, with the political backing of top decision-makers, worked in the form of change teams, and as such, played key roles in the state's capacity to formulate and pursue policy reforms – particularly in the economic sphere. During the early nineties, and as part of a major state reform that touched the economic and social spheres, change teams were also formed in social sectors such as health and pensions, and were empowered to develop and pursue policy reform.

Nevertheless, these reform proposals faced resistance at various stages of their policy process. The first and most important one was the Executive itself, where opposing views and ideologies on economic reforms confronted each other in the 1980's and early 1990's, and did so again on social reforms throughout the 1990's. Another policy node was Congress. The interaction between the Executive and Congress was a complex one, due to the characteristics of interest representation in Colombia and the configuration of the legislative chambers. For many congressmen, incentives to participate in policy process formulation were more related to the patronage resources they could tap into, than to having influence over the end result of policy decision-making. The high levels of party fragmentation and factionalism reduced the veto power of the opposition, but also severely hampered the Executive's efforts at consensus building.

Other groups that intervened in the process of policy-making such as producer associations, unions, think tanks, the media and interest groups had varying levels of influence, depending on their own political resources and the political circumstances. However, with very few exceptions, they all shared serious impediments in influencing policy-making due to lack of representation of their own membership, fragmentation and poor institutional mechanisms for interest participation.

The political context played a key role in the process of health reform. A social mandate called for the drafting of a new Constitution and a profound reform of the state, political institutions, and the economic and social spheres. The Gaviria administration saw in this a window of opportunity to pursue, with the backing of Congress, at first a series of economic reforms and later on, a set of social-sector reforms, which included education, housing, social security, and health.

However, while the Gaviria government had enough time in power to implement its first set of reforms, it only managed to formulate and legislate its social-sector reforms. The implementation of the latter occurred in a very different political context and under an administration with a different ideological stand. The policy-making strategies of the Samper administration were a radical departure from those of the Gaviria administration. Samper emphasised consensus building and a slower pace for policy change. The political management of these strategies was complicated by a political crisis that severely weakened the government, reducing its capacity for action and changing its policy priorities.

These circumstances gave enormous power to Congress and different interest groups, such as unions and business groups, who were thus able to obtain important concessions – such as salary increases, privileges, and modifications to policy content. While these political circumstances hampered the state's capacity to pursue policy change, major policy changes were nevertheless implemented in the case of the health sector reform – if at a much slower pace than first envisioned. The health reform was to become one of the most visible results of the Samper administration.



## Footnotes for Chapter 2

<sup>1</sup> Among the mechanisms trying to reverse the power imbalance between the Executive and Congress included in the 1991 constitution, is a new prerogative by which Congress may veto these appointments.

<sup>2</sup> The idea of the pendulum pattern is borrowed from the analysis of Mexican politics of Cornelius and Craig (1998), and is presented here to stress the similarities between the two countries: In spite of both being formal democracies, the political elites in both countries established power-sharing rules with similar results in the “sway” between conservative and liberal governments in power. The only difference being that, as it will be discussed in Part III, while Mexico’s power-sharing rules and elite rotation were established within the framework of a single party, in Colombia they were established within two.

<sup>3</sup> This was the case of the Revolutionary Liberal Movement, which in spite of obtaining a significant number of votes for Congress, was excluded from power-sharing in the 1960’s.

<sup>4</sup> The Turbay government (1978 – 1982).

<sup>5</sup> In the business sector, some of the most influential groups have been ANDI, FASECOLDA, ASOBANCARIA, FENALCO, ANIF, SAC, Santodomingo Group, Ardila Lule Grupo and Sarmiento Carvajal Group.

<sup>6</sup> Colombia had an economic growth averaging four points during the 70’s and 80’s and avoided the cycles of depression and hyperinflation that were common in other Latin American countries during that period.

<sup>7</sup> A policy reform that was supported by the education and health unions since it facilitated their unification in one central and national body, thus strengthening their negotiation power *vis-à-vis* the state.

<sup>8</sup> Due to the effects of the Latin American economic crisis, which were being felt at the time, and the Betancourt government’s mismanagement of the political crisis generated by the M-19 guerrilla group’s invasion of the Palace of Justice, which ended in a massacre.

<sup>9</sup> This group of public officials can be described as technocrats because they were assigned senior positions due to their technical skills, but in those positions they were expected to pursue political manoeuvring in favour of their policy agenda. See Dominguez, 1997.

<sup>10</sup> In the health sector, it passed Law 10 in 1990, which reorganised government functions within the sector by granting municipalities the responsibility for primary health care as well as first-level hospitals and health centres. The same law assigned responsibility for second-level hospitals to departmental governments, as well as the co-ordination of health campaigns. The central government was left the responsibility of policy formulation, the establishment of national minimum health standards, and the management of third-level hospitals. Central-level institutions were either reformed, as was the case of the Ministry of Health, or dismantled, as was the case of the National Hospital Fund, and the National Health Institute - which was converted into a research institute.

<sup>11</sup> The team was formed by María Mercedes Cuellar, Minister of Economic Development - previously director of the DNP also during Barco’s government; Luis Fernando Alarcón, Minister of Finance; Luis Bernardo Flórez, Director of the National Planning Department - previously Finance Vice Minister and Deputy Director of DNP also under the Barco administration; as well as the directors of the Central Bank and the Administrative Department of the Presidency.

<sup>12</sup> Who, in turn, appointed many of his rank and file to positions in the Ministry of Health.

<sup>13</sup> This first set of reform initiatives included the exchange-rate regime (Law 9, 1991 (January)); foreign trade (Law 7, 1991 (January)); financial matters (Law 45, 1990 (December)); taxation reform (Law 49, 1990 (December)); harbour privatisation (Law 1, 1990 (January)); labour regime (Law 50, 1990 (December)); housing subsidies and finance (Law 3, 1990 (January)); and government indebtedness (Law 51, 1990 (December)).

<sup>14</sup> As in the case of Gaviria’s team, Samper was backed by a technocratic team, led by Ocampo (a PhD in Economics from Yale University and previous Director of Fedesarrollo, the most important economic centre of studies in Colombia), and including the previous Barco Director of the National Planning Department (Flores), as well as Guillermo Perry (a former Minister of Energy and PhD in Economics).

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<sup>15</sup> The 1886 Constitution and its subsequent amendments up to 1968, were based on the assumption that the political horizon in Colombia was exclusively composed of two catch-all political parties. The peace process that was started in the mid-1980's aiming at ending the guerrilla war, recognised the need to open institutional political representation to other forces and groups that had been excluded. During the 1990 congressional elections, a student-led movement forced the insertion of an additional ballot asking voters whether they wanted a constitutional reform. The "yes" vote won 90% and led to the National Constituent Assembly during the Gaviria administration.

<sup>16</sup> Among others: social security, public services, education system, higher education, the provision of electricity services regime, economic and social planning, the budgetary process, financial regulation, central bank, intergovernmental transfers and decentralisation, telecommunications, civil service, transport sector and public works, and territorial organisation.

<sup>17</sup> This was particularly the case during the approval of legislation regarding the social sector. A case in point is the attempt at decentralising education, which ran counter to the interests of the teacher's union (FECODE), which called a two-month strike and forced the government to change its position.

<sup>18</sup> Once Samper was elected though not yet in office, allegations that the Liberal campaign had been financed with money from the Cali drug-cartel were made public. By the end of his first year in government, the Defence Minister – Samper's closest ally during the campaign – was imprisoned along with another dozen Liberal congressmen as a result of the investigations carried out by the General Prosecutor. In such a situation, President Samper decided to form a coalition government, in order to achieve a clear majority in Congress, since this was the only branch of government that could conduct an eventual political trial against him. This resulted in the most serious political crisis in Colombia since the early twentieth century, but President Samper managed to complete his term and the Congress declared him not guilty.

<sup>19</sup> A large number of appointments in the bureaucracy, as well as in the higher levels of government, were made according to political interests and commitments. In a similar manner, public projects were developed in regions where loyal congressmen had their political base. Government agencies were once more captured by local interests and political leaders. Pork barrel resumed in Congress, but pressing for larger quotas in budget allocations and with a more visible political use of social programs (Salazar, 1997).

## **Chapter 3. The Policy Process**

### **3.1 Introduction**

This chapter presents a brief background of the health system and the problems that were considered for its reform, followed by an overview of the reform agenda. The rest of the chapter is organised following the sequential order of a reform process, starting with problem definition and reform formulation, and ending with the initial strategies of policy implementation. Throughout this sequence, the actors involved in the process, their strategies and their influence over the reform's content are analysed.

### **3.2 Background**

In 1991, when the debate around the reform was initiated, in spite of the fact that compulsory affiliation to social security was established by law, only 20% of the population was enrolled. The Institute of Social Security (ISS) was the largest agency offering social security, but there were another 1,040 social security organisations in the country. Among them, those created by governmental agencies to provide health services to their employees (4% of the population); Co-operative Health Organisations or "Cajas"<sup>1</sup>, which offered some health services for formal sector workers organised by economic activity and their families; and the private insurance companies that catered for the highest income groups (4.5% of the population). There were also some experiments with co-operatives and mutual organisations. This spontaneous institutional development generated an overlapping of expenditure and affiliation, as well as segregation (Londoño, 1996).

The rest of the population was formally covered by services financed and provided by the Ministry of Health through its own facilities. However, it was estimated that only half of this group had real access to health care, and those who

could afford it, turned to private providers in search for better quality of care (Jaramillo, 1997).

The health reform initiated in 1991 in Colombia reflected an international trend in social security reform. It introduced a more dynamic role for both the public and the private sector and reconsidered the management and allocation of funds destined to the health sector and to pensions. But the context, the formal and informal political institutions and the main actors involved, made it peculiar to Colombia and its political circumstances in the early nineties.

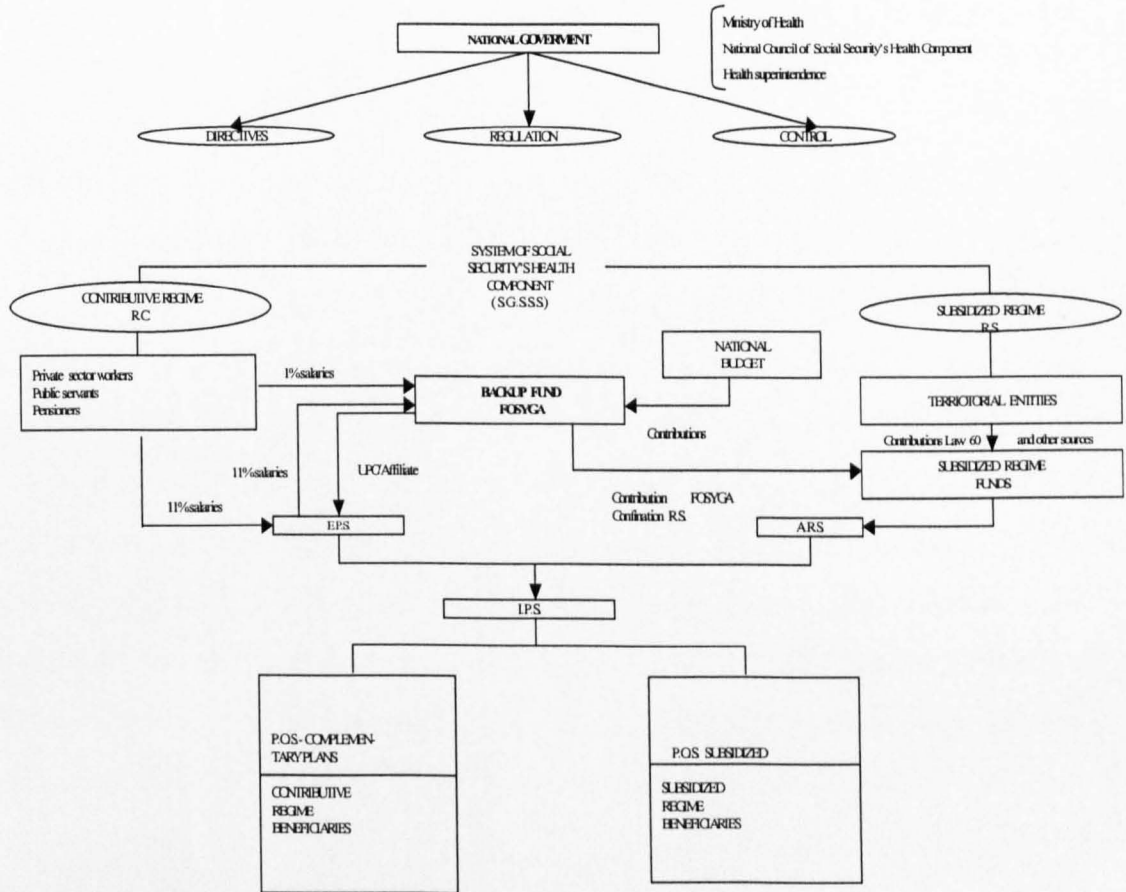
The leading objective behind the reform can be summarised as the need to rationalise health expenditure by creating in the long term a single system that would cater to all citizens and, in doing so, introduce equity and universality by eliminating the relation between purchasing power and access to a minimum level of health care. The new system envisioned in the reform intended to provide universal health coverage through a compulsory social security system organised around two health plans: a contributory health plan and a subsidised health plan. The first was to cover the employees and the independent workers who could afford to pay, and the second the poor, estimated at approximately 30% of the population. It was expected that both health plans would offer the same package of basic health care services (POS) by the year 2001 (8 years after the reform was legislated).

In order to introduce diversity and a certain degree of competition, an array of new providers were created. Some to manage health care and others to provide it. The Law distinguished the function of provision of services from that of articulating them: the IPS (Health Service Providers) supply services and the EPS (Organisations to Articulate Health Services) purchase them. Every person had to enrol in an EPS, or in the case of the subsidised health plan, to a Solidary Health Enterprise (ESS) –organisations to articulate the health services under the subsidised health plan. Competition was created in the provision of services, but not in their financing, in order to minimise dispersion of services and segmentation of markets. Free choice was established<sup>2</sup>.

The new system introduced solidarity mechanisms such as the establishment of a UPC (Risk Adjusted per Capita Payment), which potentially allowed equal resources for each beneficiary with no relation to his/her payment capacity or health risk. In the case of the contributory health plan, the premium to enrol was calculated according to the enrollee's payment capacity and not according to his/her risk probability. Families enrolled in the contributory health plan allow 1% of their payment to go to the subsidised health plan, and this contribution was expected to be matched by at least the same amount of resources from public sources. The rest of the resources for the subsidised health plan came from the national budget and resources from the health territorial authorities.

All funds were expected to concentrate in a single national account (FOSYGA) from which health management organisations were paid according to their number of affiliates adjusted by risk, age, sex, and other factors (see figure (3.1)). Under this new scheme, the ISS was formally converted into an EPS joining many others in the contributory health plan. The reformers expected that with the creation of new health providers, competition, and the opt-out option, many ISS affiliates would resort to new services and thus the ISS would diminish considerably in size – to a point where it would cease to be the central actor in the health system.

Figure 3.1: Health Reform Initiative: Resource Allocation



Source: Cuartas, (1998)

Law 100 created a National Council for Social Security in Health (CNSS) with regulatory powers, thus formally limiting the role of the MOH to the administration of some facilities and technical assistance. Provision of services was shifted from the Ministry to local agencies and independent providers; and a Superintendence was created to monitor and survey the system.

The process that culminated in the approval and initial implementation of Law 100 passed through a series of “policy nodes” where the reform’s probability of being approved and implemented were at stake, and its content was greatly modified. These were the National Constituent Assembly (ANC) (January-June 1991); the Social Security Commission established by the new Constitution to define the basic points of a social security project (July-December 1991); the reform formulation within the Executive (1992); the debate in Congress with its different stages: commissions, plenary sessions, conciliatory process (1993); the drafting of the reform’s regulatory body at the MOH (January-August 1994); the formulation of the Executive decrees (1995) and the initial stages of the implementation process under a new administration.

Most of the issues under discussion gravitated around the tension between the ideas of solidarity and efficiency that different groups would like to see predominate in the new social security system. The final result was a compromise with the inclusion of both of them as the main principles behind the reform. This tension was present since the early stages of the debate around health reform during the drafting of the new Constitution, and prevailed until the reform’s initial implementation stage. The other tension present during the whole reform process was around the new roles assigned to the public and the private sectors. The reform of the health services redefined the relations between the state, the market, and society. This was reflected in the public/private mix that was finally formulated and is currently being implemented.

### 3.3 Problem Definition and Policy Formulation

The debate around a social security reform, and with it, that of a health reform was initiated in an unprecedented environment of plural participation of the National Constituent Assembly along with issues such as in-depth state and political reform. The analysis of a social security reform was assigned to Commission V, in charge of economic, social and environmental issues. Within it, there were two dominant positions vis-à-vis the issue. One in favour of introducing competition and a public-private mix to increase efficiency, and the other in favour of promoting solidarity and universal access in a non-segmented system that preserved a strong role for the state. The former position was backed by the economic team of the Gaviria administration and the president himself, some members of the ANC and the business community; while the latter was backed by the cabinet members with a pro-state ideology, the Institute of Social Security (ISS) and organised societal groups such as the unions<sup>3</sup>.

Since no agreement was reached, the new Constitution established a consensual combination of both positions as social security principles: on the one hand, solidarity and universal care, and, at the same time, efficiency and a public/private mix in the provision of health care. Thus, the new Constitution, through articles 48 and 49, defined social security as a compulsory public service under state control, guided by the principles of efficiency, universality and solidarity. The service should be decentralised and could be provided by either public or private agencies. Finally, the new Constitution established the conformation of a Commission in charge of establishing the basis for the social security reform within six months after its formal issuance<sup>4</sup>.

This Social Security Commission worked during the last four months of 1991 at the Ministry of Labour. According to the decree that created it, this Commission was made up of members of government, unions, business associations, political and societal movements, peasant organisations, and informal workers. Issues such as health services, pensions and labour risks were discussed by the different sub-



commissions. The discussion around the health reform was co-ordinated by a former member of the ANC<sup>5</sup>, and had seven members: two representing government, two representing unions, one representative of the small businesses, one member of the Liberal party and one of the agriculture association. Those meetings focused mainly on the definition of social security; they were dominated by the unions and the government was not able to generate support around its proposals (Interview 05/12/98).

While the debate was taking place at the ANC and the Social Security Commission, the government continued to work on the development of social security reform initiatives to be included in the National Development Plan, at the Planning Department (DNP). The Plan was ready in August 1991, scarcely a month after the new Constitution was approved, which points to the fact that policy formulation was taking place simultaneously and independently from the ANC and its Commissions. Within the Executive, policy formulation was assigned to the DNP's technical policy-makers and a few experts from academia. No other group from society participated, since the goal of these discussions was not consensus building, but the formulation of policy reform initiatives with a high level of technical content.

The debate around the social security reform was therefore occurring simultaneously in two parallel arenas. While there was an inclusive debate at the ANC, with the participation of several interested actors in society, open to public scrutiny and looking for consensus, there was a simultaneous process of policy negotiation within the Executive open only to policy-makers and their bureaucratic factions, and away from public scrutiny. Therefore the health policy defined in the Gaviria administration's Development Plan presented the government's initial position towards the reform, even though it tried to introduce the principles defined by the ANC and incorporated in the new Constitution.

The National Development Plan of President Gaviria – called “*La Revolución Pacífica*” – did not consider a health reform as such. The chapter on health policy

had as main guidelines the improvement of efficiency within the system and the strengthening of local health services. Nor did it contain the social security reform project, and instead assigned the responsibility of formulating it to the Social Security Commission, following the ANC's mandate. However, the Development Plan did contain most of the elements that were later to be part of the social security and health reform initiatives. These were the need to expand coverage to family members of social security affiliates, eliminate duplication in the provision of health services, and separate the health component of social security from pensions. It also addressed the need to continue the decentralisation process, allow the social security system to contract out services from a public/private mix of providers, and introduce provider eligibility. There was also a suggestion to start a pilot experience in pre-paid health care for the poor funded with public resources in a voucher scheme – thus establishing demand-based resource allocation and target subsidies<sup>6</sup>.

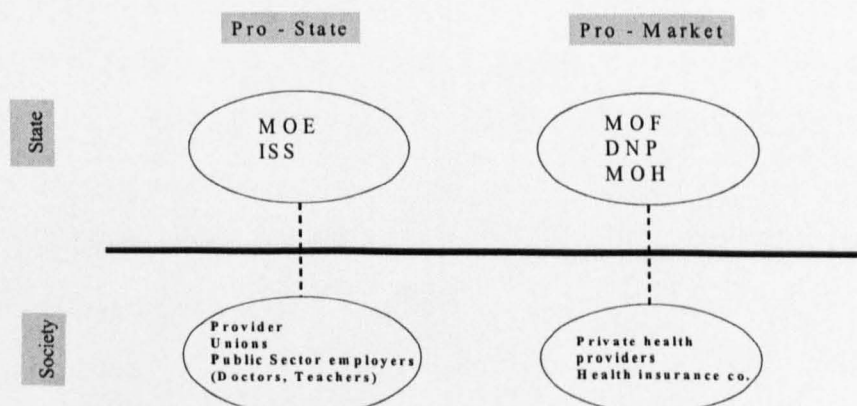
But beyond these general guidelines presented as the government's monolithic position, disagreement around the social security and health reforms between two main factions within the Gaviria administration prevailed. The Social Security Institute and its allies in the cabinet – such as Minister Samper – had a pro-state position, while the DNP and the rest of the economic team – including the Ministry of Finance – had a pro-market approach. Four different reform proposals were at stake. The one presented by the DNP was closer to President Gaviria's own ideas, and coincided with the state reform being promoted by his government in elements such as the introduction of competition and the definition of a new role for the private sector in the promotion of efficiency. According to some officials who opposed this proposal, it considered introducing the Chilean model of social security in Colombia, privatising the health system and giving the principle of solidarity a secondary status (Interview 05/17/98).

At the other extreme, the ISS wanted to maintain the monopoly of the state in social security, introducing competition only at the level of provision of services. The Ministry of Health<sup>7</sup> presented a compromise between these two extreme

positions that would maintain the solidarity mechanism, while introducing some degree of competition<sup>8</sup>. Finally, ASMEDAS, the unions' association, wanted to maintain the monopoly for the ISS in every aspect – affiliation and provision of services – and expand its coverage under the same conditions<sup>9</sup>.

A very politicised debate continued in society after the ANC's Social Security Commission's mandate had ended. It involved many actors and forums in Bogota and in the regions, such as university seminars, experts' discussions, and international seminars, among others. Among the groups that were involved were unions; think tanks, such as Fedesarrollo, Fescol and Consenso (the team that left the ISS with Cecilia López's resignation); NGO's such as Fundación Corona, Instituto Fes de Liderazgo and Metrosalud; and universities<sup>10</sup>. The two factions in government not only were present in different roles in most of these debates, but also promoted some in alliance with the groups that favoured each of the two positions. Figure (3.2) shows these two coalitions across state-society lines that could be recognised along the main two policy positions: those who advocated solidarity and a predominant role for the state (ISS, Fescol, state unions), and those who advocated competition, efficiency, and a stronger role for the private sector (DNP, Ministry of Finance and business with interests on insurance companies).

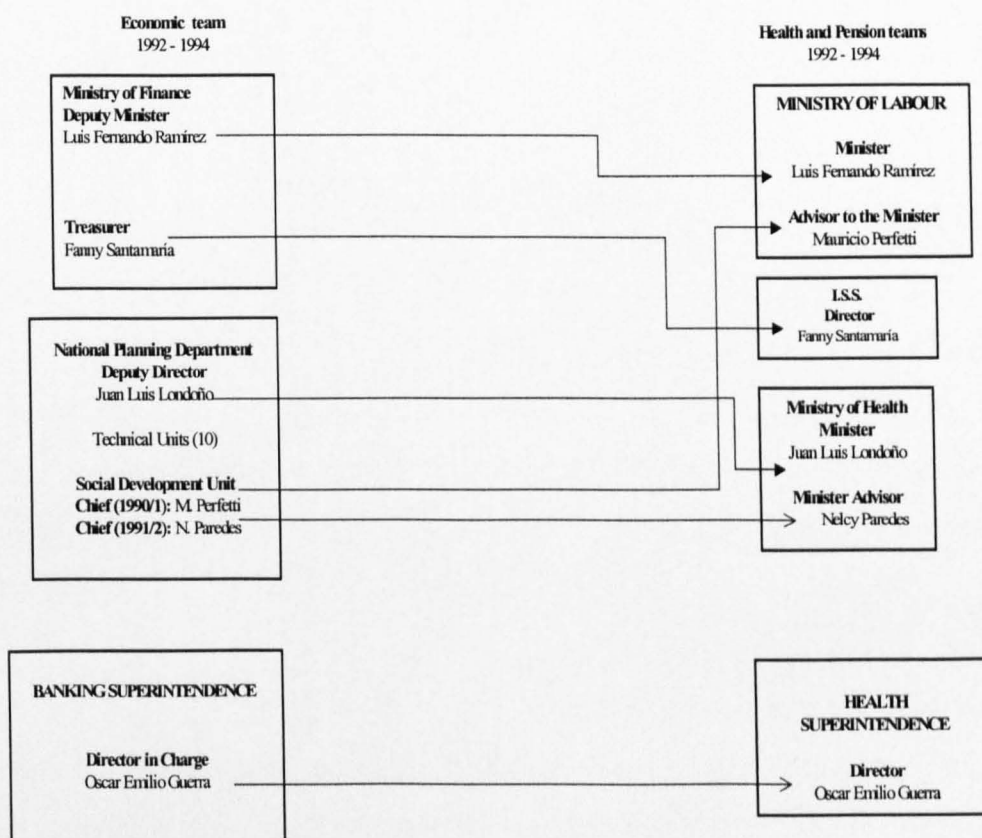
Figure 3.2: Coalitions Across State - Society Lines



As the Social Security Commission approached the end of its mandate without reaching an agreement, and with public debate around the issue still going on, the government moved on in order to jump-start the social security reform. First, in December 1992, it promulgated a series of executive decrees related to state reform, which included the transformation of the ISS, the Ministry of Health, the Health Superintendence and the public-sector employees' social security institutions<sup>11</sup>. Through these executive decrees, the government streamlined key elements that would facilitate the health reform's implementation, while circumventing Congress and the need for consultation and consensus building that a bill would have required.

Second, President Gaviria sought to end the fierce competition between factions within the Executive around the social security agenda, and to consolidate a single position within his government in support of the pro-market initiative. He dismantled the pro-state faction in a cabinet reshuffle during May 1992, in which he removed Cecilia López, the Director of ISS who had been leading the opposition to the DNP proposal, and replaced her by Fanny Santamaría. Santamaría, who was at the time a senior official of the Ministry of Finance, was in favour of the economic team's technocratic proposal. Simultaneously, Luis Fernando Ramírez, a young conservative with many years of working experience in the private sector, and Deputy Finance Minister at the time, was appointed Labour Minister. Thus, President Gaviria put members of the economic team directly in charge of the social security reform by assigning them to the key government agencies involved in the reform, and buttressed the private sector's political support in its favour. Figure (3.3) shows the key members involved in the social security reform, their positions in the economic agencies, and the appointments they were given.

**Figure 3.3: Economic Team Members Assigned to Social Security Reform**



As part of this same effort to ensure the political feasibility of the pensions reform, President Gaviria decided at this stage to abandon the health reform. In his view, the government did not count on enough financial, institutional and political capital to reform both health and pensions simultaneously. His priority was clearly set in the pensions reform, as an element of the economic adjustment still to be completed<sup>12</sup>, and in his view, the complexity and visibility of a health reform initiative could jeopardise the political feasibility of passing a pensions initiative in Congress. His perception was further reinforced by his advisors, who felt that

there was not enough support behind the measures the government was envisioning for the health reform (Interview, 05/17/98b).

Thus, in September 1992, the government submitted a bill to Congress to reform social security, which addressed only the pensions component (Proyecto de Ley 155, September 1992). The bill was called the Law for the Creation of Pension Savings (Ley para la Creación de Ahorro Pensional). The Congress debated the proposal in December 1992. The bill found opposition from two fronts. From the unions, which feared that the reform would cut their benefits – the proposal included more requirements to join the system and offered less benefits – and from those groups that did not disagree with the proposal, but wanted to have the health component included<sup>13</sup>. The resulting coalition responded simultaneously to two agendas: one responding to a genuine interest in ameliorating the health system; and the other using its inclusion as a strategy of delay against social security reform, counting on the health reform's formulation being a complex and long process.

In a meeting with President Gaviria, the legislators effectively conditioned the pensions reform to the simultaneous inclusion of a comprehensive health reform in the same bill to be re-submitted to Congress. This interaction between the Executive and Congress makes health reform in Colombia a unique case. One in which it is Congress, and not the Executive, which stands behind the inclusion of a comprehensive health reform initiative on the public agenda. Thus it was in Congress that the reform found the political support to force the Executive to reconsider its inclusion in the social security reform.

President Gaviria thus formed a high-level technical team within his government to develop the proposal in detail. The team was co-ordinated by the DNP, and involved officials from the DNP, the Ministry of Health, the Ministry of Labour, and the ISS. This team's proposal – called the Hatogrande Proposal – was strongly influenced by the neo-liberal model used by the Gaviria administration in the economic reforms that had also permeated the pensions reform. However, it

departed from the radical health reform proposal of the DNP, and took a more moderate position by responding to some of the concerns raised during the bureaucratic in-fight that had resulted in the ousting of the pro-state faction. It proposed a health system based on provider competition, compulsory affiliation and universal access to health care, with risk distribution and cross subsidies among income groups, and defined two health insurance plans, one contributory and one subsidised<sup>14</sup>.

The team presented the project to the DNP's director, Montenegro, a key member of the economic team, and to the deputy director, Londoño, who was soon to become health minister. They approved it. It was also shared with the then Minister of Health, Gustavo de Roux, who did not oppose it, but was not committed to it either; since he found it too complex for the institutional capacity of the country, and at the same time too partial, in that it sought to transform the Ministry of Health, but not the ISS (Interview, 05/27/98).

The Hatogrande proposal was presented to President Gaviria on November 16, 1992. He found it too complex and was again concerned about the possibility of it jeopardising congressional approval of the pensions reform. He had in mind a health policy proposal that would respond to the legislators' concerns just enough to have them pass the pensions reform. In other words, he saw the need for a health reform initiative only as part of his negotiation strategy, but was yet to be convinced to include a comprehensive health reform in his policy agenda. Thus, he rejected the proposal and instead demanded the formulation of a small health initiative to create community health-care organisations – called Health Solidarity Enterprises (ESS)<sup>15</sup> – and to channel through this new health service scheme, a large amount of fresh resources into the health sector.

Two weeks after this meeting took place, and after the resignation of De Roux<sup>16</sup>, Gaviria named Juan Luis Londoño Minister of Health on November 30, 1992. A liberal economist, Londoño stemmed from the core of the government's economic team. As DNP deputy director, he had been directly involved in the government's

technocratic proposals related to social policy – social security, health and education – and had been supervising the Hatogrande proposal. Londoño's appointment marks the consolidation of the economic team's control over the social security reform, since it followed the cabinet reshuffle, some months earlier, in which some of its members had been appointed to the ISS and the Ministry of Labour. From this time on, Londoño played a crucial role in the health reform process, and became its clear leader.

The initial health reform bill presented to Congress by Londoño in December 1992 was very limited in scope following President Gaviria's demand to constrain its content to the minimum necessary to respond to the Senate's demands. But the Congress considered it a half-hearted effort and rejected it once more, keeping its stand to condition the pensions reform to a more comprehensive health reform initiative. President Gaviria realised at this point that the Executive was losing political leadership and control over the social security reform, since now, it was being credited to the Legislative power. He thus moved swiftly to regain ground by concentrating efforts in putting together a sweeping health reform with more ambitious goals than those first intended by Congress. Therefore, with President Gaviria's support, Londoño began to work on a comprehensive health reform taking as a departure point the Hatogrande project, which by then had been discussed with the ISS, Co-operative Health Organisations (Cajas), pre-paid medicine agencies, local health authorities and experts, and had reached some degree of consensus.

For this purpose, Londoño appointed a small group of policy-makers with no previous experience at the Ministry of Health – which will be called the health change team – under his direct control and isolated from the rest of the ministry<sup>17</sup>. He then immediately proceeded to construct a closely-knit network of support around the reform and the change team itself. First, he concentrated on building strong alliances and ensuring the support of members of the government's economic team in senior positions at the key ministries – notably Finance and the DNP – which will be called vertical networks.



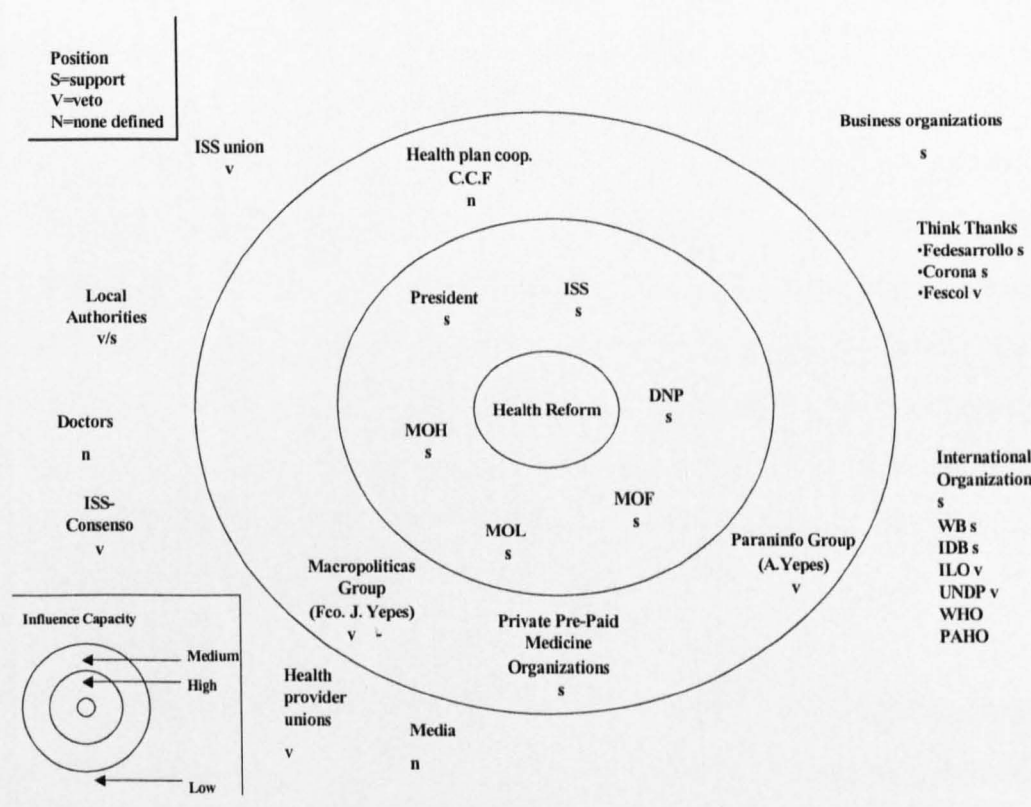
Second, he and other health team members reinforced informal links with mid-level officials in government agencies such as the Labour Ministry and the Banking Commission – which will be called horizontal networks. The latter were to provide the health team with strategic information and knowledge, and were also to offer the team informal opportunities to make their case in these government agencies even when their senior official's support seemed to falter. Also as part of these horizontal networks, the team established selective links with other actors within the MOH, such as the finance staff within the ministry, which was more receptive to a health reform with an economic perspective.

And finally, Londoño and his team started to establish informal links – with no commitments on either side – and tapping the expertise and knowledge of groups in society such as think tanks, academia, business organisations, insurance and pharmaceutical companies, doctors' associations, private hospitals and others – which will be called state-society networks<sup>18</sup>.

The change team worked on the new health reform proposal during early 1993, and had it ready in April, when congressional sessions were resumed. Following the institutional procedure, the Executive submitted an amendment to the initial social security bill. The amendment finally incorporated an integral and comprehensive proposal for social security reform in both pensions and health. The content of this health reform reflected a compromise between the two extreme positions that had permeated the policy debate around it from its outset in the different arenas where it had been discussed so far. Thus, along with efficiency, it included universal coverage and solidarity as its main principles. These principles were reflected in the reform's policy components, such as two health plans – a contributory one for those families with either a formal employment or with sufficient purchasing power, and a subsidised one for those families with informal employment and no purchasing capacity–, market competition mechanisms; and the establishment of a single health insurance fund (FOSYGA) in order to maintain the principle of solidarity among affiliated members of both health plans.

Figure (3.4) shows a political map of the principal actors who participated in this stage of the reform process, and their position *vis a vis* the reform (veto, support, or non-defined). The health reform has been placed at the centre. The relative distance of each actor with respect to the centre is an indication of its relative power to influence the reform's content.

**Figure 3.4: Reform Formulation Stage (1992 –1993):  
Political Map**



### 3.4 Legislation

When the final health reform bill was submitted to Congress, it was turned to the respective commissions in the Upper and Lower Houses. Commission VII, in charge of Social Affairs, received it for discussion. As was the case in the ANC, the members of this commission represented a plurality of political forces that went beyond those present within the Executive and the two traditional political

parties. The Liberal and Conservative parties were not dominant and there were representatives from left-wing parties such as the UP and M-19, and civic groups. The proposal was perceived as an attempt at dismantling and even privatising the ISS (Interview 05/12/98). This caused a severe reaction among those members of the commission who wanted to preserve the ISS monopoly and the social security benefits of public sector employees. The Law was debated with intensity at this stage, and several modifications were introduced.

The Congressional Commissions generated a new long public debate around the social security reform, in which many groups in society were consulted. The main actors intervening in the discussions were the Minister of Health, government officials, local health authorities, private health institutions such as pre-paid medicine organisations, health providers, the pharmaceutical industry, the Colombian Medical Federation (ASCOFAME), the Colombian Hospital Association, the National Medicine Academy, the insurance companies, producer, industrial and financial associations (Consejo Gremial, Andi, Asobancaria), labour organisations and unions (Asmedas, Anea, Sintra, ISS), Co-operative Health Organisations (Cajas de Compensación), NGO's and foundations (Corona, Fundación FES de Liderazo), think tanks (Fescol, Consenso, Fedesarrollo and Metrosalud), and independent opinion leaders.

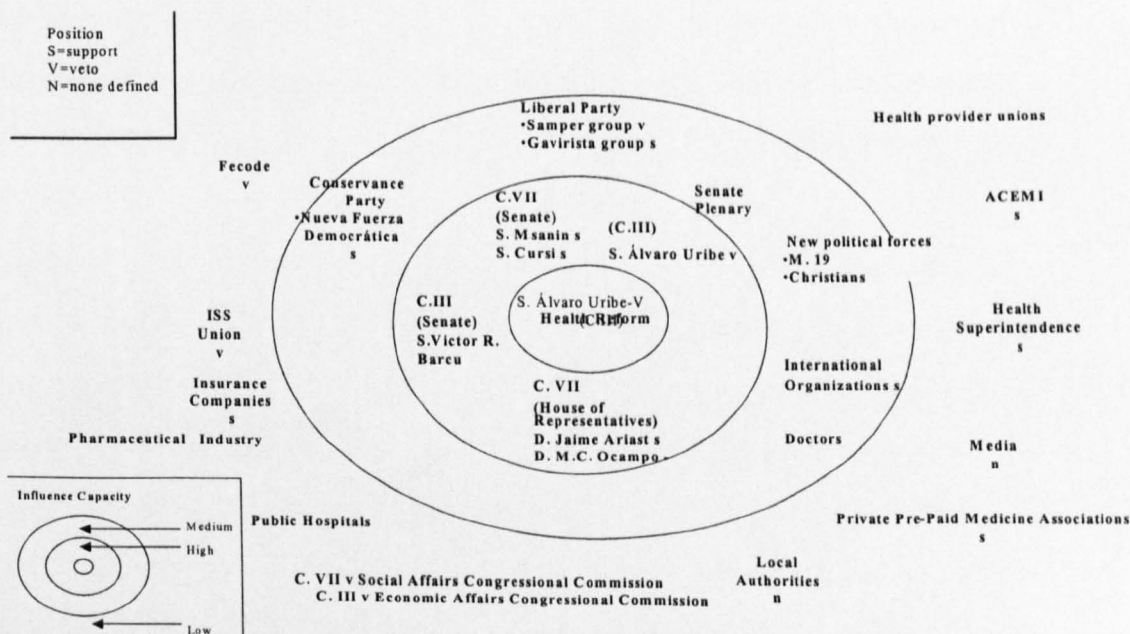
During this process, Londoño and members of the health change team held meetings with each of these actors in order to lobby the proposal. Interviewees pointed to the high level of technical content of these meetings (Interviews 05/17/98, 08/20/98, 08/22/98, 10/28/98). This perception helped the change team show that policy decision-making was taking place from a neutral political stand, and that it was responding exclusively to rational objective considerations. But also, the team's counterparts were often overwhelmed with information and a technical discourse that was difficult to grasp and thus to reject.

Two dominant coalitions coalesced in Congress. One in favour of the government's proposal, composed of the business associations, some factions of

the traditional parties (Liberal and Conservative), private health providers, co-operative health organisations (Cajas) and international organisations; the other opposing the project, including the unions and left wing political movements<sup>19</sup>. Other groups did not have the same level of influence over the reform. That was the case of users and other civil society groups. The doctors were represented by their professional organisations, whose leaders supported the reform on the grounds of the principles it was based on, such as solidarity, equity and universality. However, when the reform entered its implementation stage, these doctors claimed that they were not represented by their professional organisations' leadership and disavowed the reform (Interviews 05/17/98b, 10/25/98, 11/10/98).

Figure (3.5) presents a political map of the principal actors involved at this stage of reform legislation and their positions *vis a vis* the reform's law initiative. The health reform has been put at the centre, and each actor's relative distance from it represents their relative power to influence the reform's policy content.

**Figure 3.5: Reform Legislation Stage (1993):  
Political Map**



Some interviewees perceived the policy debate around the reform at this stage as a democratic and participatory exercise; but others felt it was a dilatory strategy used by Congress as a negotiating chip with the Executive. Yet in retrospect, most saw it as a formality to comply with the political demand for open participation and legitimise the government's proposal, while the real process of decision-making was taking place elsewhere within the Executive (Interviews, 08/24/98, 11/05/98, 11/06/98). While it is difficult to assess the degree of influence of this exercise on the Executive's policy choices for the reform, it is clear that it did work as a sounding board that the government tapped on in order to assess the political feasibility of particular reform components, as well as to learn about the interest group's positions about them.

The debate in Congress was prolonged for more than a month and by May 1993 not a single article had been approved. The Executive's officials who had been in charge of lobbying the social security reform – mainly the Minister of Labour and the Minister of Health – perceived that they had gone as far as they could in the negotiation, without obtaining approval, and thus turned to President Gaviria to solve the gridlock. President Gaviria called a meeting with the leadership of the Liberal and Conservative parties and obtained an agreement by which both parties would secure enough votes to have Law 100 approved (Interview, 05/17/98b).

The Legislative Commissions concluded their work and the bill was passed to plenary sessions for its discussion. The most significant modifications to the initial bill were done at this stage, and all its articles were revised again. This reflected the persisting disagreement around the Law and the need for negotiation. The full Senate discussed the Law between August and November 1993. After the reform was modified and approved in the Senate, it was sent to the Lower House, where a Commission studied the project – with the active lobbying of the Minister of Health.

After the project was approved at the Lower House, a Conciliatory Commission with members from both chambers and with the participation of the Ministry of Health, had to be created and assigned the responsibility of unifying the approved proposals stemming from the Upper and the Lower Houses, since the controversy around the reform initiative had generated incoherence among them.

The debate coincided with a period of intense political mobilisation with union strikes and several protests. The teacher's union (FECODE) and the oil workers' union (USO) were particularly active against the decentralisation law (Law 60) also being discussed in Congress, but they were also against being incorporated into the new social security system under Law 100. The Executive agreed to exempt both labour groups and the armed forces as a strategy to diminish organised resistance to the reform.

In December 1993, the Law was finally approved by Congress, and ratified by President Gaviria. The new Law for social security reflected, in different degrees, the array of positions held by the groups involved in the debate. In order to accommodate the vast array of interests and to jeopardise a minimum number of interested groups, the Law was purposely written in very general terms, thus leaving a vast space for interpretation and to policy definition that had to be detailed in the following stages. This opportunity was seized by the health change team during the preparation of the regulation package under its jurisdiction, to bring the reform's content closer to the proposal they had originally presented. By the same token, the lax wording of Law 100 also opened an opportunity for the groups against it to alter it during its implementation stages, seriously undermining the reform's possibilities of consolidation.

### **3.5 Regulation**

After the approval of Law 100, the MOH was assigned the responsibility of preparing the 25 regulatory decrees that composed the secondary law package, in consultation with the CNSS, and to be endorsed by the president. Thus the reform

moved back to the control of the Executive, and away from the Legislative arena and the process ceased once more to be a participatory and plural one. Only the change team along with a few experts who were sporadically invited, participated in the regulation package's formulation. The information that was shared with groups outside the state was carefully selected and access to decision-making and to the policy options being studied was very controlled.

The health change team was aware that it had eight months before the end of their term in office due to the change of administration. It wasted no time in trying to ensure the reform's consolidation, or at least to limit the possibility of its reversal in the short term. To this end, it concentrated on three key activities: preparing the regulation package, creating the mechanisms through which fresh financial resources would be allocated to the new health system, and training the new providers that were to play a key role in the new system – such as health care providers and especially, health management organisations (EPS)<sup>20</sup>.

It was their belief that setting the new rules of the game would bring about in the mid to long-run the needed institutional change for the new health system to emerge once they had left office. For this reason, the team classified the reform's components according to their priority, since there was not enough time to develop the regulation for the reform in full, putting particular emphasis on creating and setting up the rules for the new providers, even if at the expense of establishing the details of the transformation of the old existing ones – like the ISS and the MOH services. Thus key points of the transition were not defined, such as the gradual incorporation of the very poor to the subsidised health plan and the transition from supply to demand subsidies, among others. These components left in a state of incompleteness proved to be a serious obstacle during the reform's implementation process (Londoño, 1996).

This probably explains the fact that, contrary to what was asserted by change team members and DNP officials at the time, other actors who were also interviewed pointed out that the change team tried to define more precisely some aspects that

were left too open in the Law, and that they did so according to their own criteria. They favoured efficiency over solidarity and universal access, by concentrating on the strengthening of the private sector's role, the introduction of competition, provider choice and financial sustainability. For instance, they defined reductions in the POS content that was approved, having as the main criterion cost-effectiveness analysis: high cost treatments without proven efficiency were not included in the package.

Some critics<sup>21</sup> asserted that this stage of the reform process could be considered a return to a segmented system, since in spite of the agreement in Congress around a single POS, the team in fact defined two different ones. They also pointed to the fact that the priorities defining the regulation favoured the activation of the role of the private sector and established no incentives for the transformation of the public-sector actors (Interview, 08/19/98).

The change team tried to address policy options with criteria as objective and technical as possible, and for this, it resorted to the specialised support of national and international experts who played a key role in this part of the reform process. However, the most technical members of the team felt that in the end, several political concessions were made in order to ensure its feasibility (Interview 05/27/98). For some members, this helped ground the reform on more feasible scenarios, while for others, the concessions made were of such a nature that they seriously jeopardised the reform as it had been envisioned from the start. The centre of this controversy was the definition of the content and scope of the POS.

The composition of the change team working on the reform at this stage was modified: Londoño brought to the group highly qualified persons such as Maria Luisa Escobar, Teresa Tono and Beatriz Londoño, some of whom had been working on the technical studies backing the reform since the time it had first been discussed in Congress. Most of the team members working during this period recall it as a frantic atmosphere with excruciating journeys in a race against the



clock. Between August 1 and August 5, 1994, President Gaviria's last week in office, 22 key Executive decrees regarding health reform were approved.

The team pointed to the scarcity of time as the reason for the few consensus building activities they conducted with other groups in the sector during this period, and particularly with the incoming administration members who were going to be left in charge of the health sector. Change team members do assert that they did have meetings with the incoming team, but it seems that the focus of these meetings was placed on informing the newcomers about the reform and educating them about its benefits, rather than on exchange of information about the state of affairs of the reform process. In fact, the new team specifically asked to see the work that was being done on preparing the regulatory package, but this was denied. As a result, the new team felt alienated and the possibilities of conducting a co-operative transition were severely undermined.

Also, although the Ministry consulted the general issues of the secondary law development with the new National Health Board – but not the details – the fact was that the board had neither the time, nor the training to debate them in depth, and thus another opportunity for ensuring a more predictable transition was lost.

### 3.6 Initial Implementation

The reform's implementation began in 1995 under a new administration and with newly elected local authorities. In August 1994, a different faction of the Liberal Party had come to power led by President Samper. Given the party system in Colombia, the fact that the new administration stemmed from the same party as the Gaviria administration did not mean that it shared the same policy platform, or even the same ideology. Both groups represented rather opposite ideological positions on the role of the state, as well as on state-society relations. President Samper and his group had been part of the government faction that had been openly critical of the Gaviria administration's economic and social reforms.

In the health sector, this meant that the group of policy-makers that had vehemently opposed the reform's pro-market approach, and had been ousted from the previous government, was back in power, and in senior positions from where it could now defend the status quo and particularly the integrity of the ISS, as a means to preserve the leading role of the state in health provision. Only two members of the health change team who had been leading the reform during the Gaviria administration stayed at the MOH, and for a short period of time<sup>22</sup>.

The political map around the health reform coalesced around two coalitions. One seeking to halt the reform process, and the other supporting the continuation of the process. The former counted on actors that until then had been precluded from participating in the reform's formulation and legislation stages, and that now took a central role because their co-operation was indispensable for the reform's implementation. This was the case of health workers, doctors, senior officials of government agencies – particularly the ISS – and local governments, among others.

The pro-reform coalition counted on the new providers created by the reform, such as the EPS and the ARS, some local governments<sup>23</sup>, and those societal groups who were having access to health services for the first time – notably the

poor. The reform was also backed by international support in the form of loans (IDB and World Bank) – which had been secured by the change team under the Gaviria administration – to support the health reform’s initial implementation, and by the involvement of international organisations and foreign universities in advisory roles.

During the first 20 months of the Samper administration, three different Health Ministers were appointed<sup>24</sup>. The constant changes of health ministers was accompanied by a high circulation of senior officials at the MOH, and even the technical teams did not remain constant, further undermining any effort at institution- building around the reform. This slowed the reform’s momentum due to the constant changes in policy direction and contradictory signals, and seriously affected the initiation of the reform’s implementation stage. The passive resistance stemming from the bureaucracy within the health sector public institutions did not only respond to the lack of information and technical assistance during the reform’s initial implementation, but to a ‘wait-and-see’ strategy expecting that each new minister would express opposition to the reform and effectively bring it to a halt.

President Samper appointed Alonso Gómez<sup>25</sup> as his first Minister of Health. During the Gaviria administration, Gómez opposed the health reform on the grounds that it had a pro-market approach and the fact that it intended to divert resources away from the tertiary level of the health system. He had been further alienated by the former health change team’s lack of political will to share the preparation of the new Law’s regulatory package with the Samper health team, of which he was part.

While he was in charge of the MOH, his decisions generated confusion among the health sector actors, since he was openly against a significant number of measures that were expected to start implementation during his term in office. His position against the reform was at first supported by doctors, health-sector unions, and government agency officials who were interested in stopping and reverting

different aspects of the reform. It also ran along the lines of the political strategy of the Samper administration, who resorted to the political support of organised state groups – notably unions – to retain power, and therefore was reluctant to affect their interests. Gómez sought to redress some of the core elements of the health reform. For instance, he promoted an Executive decree overriding the new mechanisms of resource allocation within the health system, and reallocated the resources that had been secured for the cost of the reform's transition into health manpower salary increases.

But he soon lost the support of the doctors and the provider unions – due to his autocratic style – and was criticised for wanting to revert policy changes that had been legitimised during the legislation process. When political pressure started mounting, and following the advice of several of his cabinet ministers, President Samper asked Gómez to resign and appointed him presidential advisor for health policy – a position of influence from which he continued to undermine the reform process<sup>26</sup>.

In July 1995, Augusto Galán Sarmiento<sup>27</sup> was appointed new Minister of Health. He belonged to the “Galanista” faction of the Liberal Party<sup>28</sup>, whose support President Samper was seeking. While not having had previous experience in the public health system, he had followed the reform process closely, and believed in it as a social project. His time in office was very short – less than seven months<sup>29</sup> – but the perception about his role during those months varies greatly. In spite of his short time in office, he played a key role in putting the reform back on track, after former minister Gómez's attempts to bring it to a halt.

In a *tour de force* with President Samper<sup>30</sup>, he succeeded in having an executive decree (Decree 2357) signed that reverted the one in force presented by Gómez (Decree 2491). This decree had a significant role in re-starting the reform process by re-activating Co-operative Health Organisations, the EPS and the ESS. With this new decree he thus re-established the basis for public-private mix and competition in health services provision, as well as the mechanisms that would

allow the health subsidies to follow demand instead of supply. This new change in policy direction was welcomed by national health experts who had been reaching a greater consensus around the principles on which Law 100 is based<sup>31</sup>.

The results of this seemingly subtle change in decrees were not visible until the second half of 1996, when María Teresa Forero de Sade was appointed Minister of Health<sup>32</sup>. She brought to the ministry her experience in the public sector as well as in the private sector – where she had been Director of ACEMI. She was to remain in office for the rest of the Samper administration. It was during this period that, after two years of delay, the health reform implementation was started in a systematic manner. Forero de Sade did not promote major changes in policy direction. Instead, she focused on putting into practice what was stated in Law 100.

Opposition to the reform did not cease. Several initiatives were presented to Congress to amend Law 100, although none of them progressed. For instance, the Finance Minister proposed, in 1996, a return to the state's monopoly in the provision of health services for the poor under the subsidised health plan, and the exclusive provision of services – through public hospitals and health authorities. Other proposals aimed at reducing the central government's transfers by half – which would have a negative effect on the subsidised health plan as well. This was due in part to the financial difficulties the government was facing, but also to the prevailing view in the Samper administration that the public sector should be the central provider of health services for the very poor.

Aside from the effective resistance to change, the transformation along the lines of the reform of the old providers in the health-care system – such as the ISS, the local health authorities, and public hospitals – faced formidable difficulties. The lack of information about the day-to-day operation of several components of the reform, and the slow allocation of the fresh funds that had been secured for their implementation – notably the resources to be allocated to the subsidised health plan – were serious hurdles<sup>33</sup>. But also, the uneven capacity of old and new

providers to meet the reform's requirements on information, organisational and managerial resources, and thus absorb and/or implement policy change.

This was particularly the case in what pertained to the scarcity of trained personnel able to assume the new complex functions that were to be put in operation under the new system – such as those entailed in the separation of the financing, articulation and provision of health care. Above all, the financially fragile ISS's failure to transform itself, reduce its size, and abide by the regulation of the new health system put the financial viability of the new health system at risk in the medium to long term.

Six years after the approval of Law 100, the evolution of the health reform's process as well as its first outcomes continued to be a cause of much controversy among actors directly involved, and among interested observers. In retrospect, the economic team that backed it during the Gaviria administration sees it as a successful attempt at bringing about significant change in the health sector, and thus one of the most important reform initiatives that took place during this decade.

What makes the Colombian experience unique is the fact that due to the incorporation of a mix of principles in the reform – efficiency, universality and solidarity – which resulted from its political process, those groups who at first opposed the technocratic proposal, adopted the reform in its final form (Law 100), and thus pursued it and protected it when it was put in serious jeopardy by the different actors that favoured the status quo. One official of the Samper administration and member of the group that first objected the Gaviria initiative stated: “we felt represented with the final outcome of the reform, which introduced principles of universality and solidarity. This is the reason why we have defended the reform against the resistance during the implementation process” (Interview, 08/26/98).

According to the MOH<sup>34</sup>, since the formal start of the reform's implementation in January 1995, the coverage of social security in health has increased from 23% to 54% in 1998. Of those enrolled, 66% (21.5 million people) are in the contributory health plan and 33% in the subsidised health plan. The resources allocated to the health sector have doubled and there have been significant institutional changes, such as the creation of 30 EPS<sup>35</sup> and the Agencies for the Management of the subsidised health plan. The change of public hospital funding from supply-based to demand-based is on its way, if with difficulties. Therefore, while not yet consolidated, the reform seems to have had a significant impact on the expansion of coverage and institutional change.

### 3.7 Summary and Main Points

Throughout the process of health reform definition, formulation and legislation, and in the different policy nodes where it took place, actors coalesced around two main positions about the principles that Colombia's new health system should prioritise. One gave priority to efficiency and market competition, and the other to equity and state intervention. Law 100 reflected a compromise between them, and mandated a health system which introduced competition and involved the private sector; but at the same time maintained the role of the state not only as regulator, but also as service provider. In spite of the consensus-building process that this mixture of principles in the reform's Law reflects, Colombia's institutional context gave the health change team many opportunities to determine its final policy content.

At first, most of the reform formulation took place within the Executive where the change team was shielded from political pressure. When the team's initiative was presented to Congress for legislation, it counted on the direct political support of the president. Furthermore, once the new Law was passed, the draft of its regulation package was assigned exclusively to the change team, which once more was able to determine the reform's policy content away from public scrutiny.

Law 100 reflects an international trend in social security reform, but the political context, the formal and informal institutions and the main actors involved in its process, made it peculiar to the Colombian situation of the early nineties. The Law was the result of an intense debate where many "policy nodes" were important: the National Constituent Assembly (January - June 1991); the Social Security Commission mandated in the new Constitution (July-December 1991); the Executive during reform formulation (1992); Congress (1993); and the Executive again during the definition of regulation (January-August 1994), the transitional executive decrees (1995) and initial implementation (1996 – 1999).



The actors involved in the policy debate around the reform changed according to the stage of the reform process and the policy node it was in. During the very first stages of reform formulation, the main actors were the members of the National Constituent Assembly, particularly the members of the Social Security Commission it created. But as soon as the Executive incorporated the health reform into its policy agenda, the central actors of the policy debate were the two bureaucratic factions led by the National Planning Department and the ISS, respectively. These two factions were to establish close links with like-minded groups to enforce their positions in the battle to influence the reform's content. Among these actors were unions, think tanks and academic groups.

By the time the proposal was presented to Congress, the Ministry of Health, already under the control of the economic team, became the central actor leading the reform, and remained so until the end of the Gaviria administration. The central actors changed once more as the reform entered its initial implementation stage coinciding with the change of administrations. Provider groups such as health manpower unions, the bureaucracy of the health system's old providers, and local health authorities took centre stage as their co-operation was needed to bring about policy change.

A variety of actors within the state and in society tried to influence its policy content using different formal and informal means to access decision-makers and the central actors described above. Their success at this endeavour varied greatly and constantly depending on their means to make their voice heard, but also on the degree of permeability of the institutional context in which the reform was taking place. Local health authorities, unions, congressmen, medical associations, health experts; private research institutes; health workers; co-operative Health Organisations, pre-paid medicine groups, productive and industrial associations, pharmaceutical organisations and politicians at different levels, tried to influence the reform's formulation, legislation and initial implementation. The users of the system, the consumers, remained at the periphery of the reform process and were not represented, formally or informally.

At the centre of the reform process, and with great power to determine all these actors' access to policy decision-making, was the health change team, led by Juan Luis Londoño, the Health Minister. This small group of highly technical policy-makers worked in isolation and shielded from the rest of the actors thanks to the direct support of the president and the economic team. The group only interacted selectively with some of these actors when it was forced by the institutional context – for instance, when having to lobby the reform's approval in Congress – or when it needed information and/or knowledge related to the reform. To a lesser degree, the team tried to institutionalise change in view of the short period of time they expected to be in power, and thus in control of the reform.

The final policy content of the reform continued to be a matter of great controversy even as it entered its implementation stage. However, many of the actors that had been the visible heads of the rival coalitions in the competition to influence the reform's content during its formulation and legislation stages, perceived that the end-result did represent their policy views, and thus defended the reform's implementation when resistance mounted.

### Footnotes for Chapter 3

<sup>1</sup> Among these, the coffee labourers' and bank employees', among others.

<sup>2</sup> Families can join any EPS for a minimum period of one year, after which they can terminate their contract and join another EPS. On the other hand, an EPS can not reject potential enrollees.

<sup>3</sup> During this time the debate around the Chilean model was very important. The experience of the ISAPRES was evaluated, and it was seen as a highly inequitable model where competition had broken the solidarity mechanisms. Nevertheless other principles of the Chilean model were seen as desirable, such as to end the monopoly and to incorporate the private sector into the system.

<sup>4</sup> Constitución Política de Colombia, 1991 (Article 57, transitory).

<sup>5</sup> Antonio Yepes, who in 1994 became director of the ISS under President Samper. During the debate that took place at the ANC, the pro-state ISS group found in him a good ally.

<sup>6</sup> Departamento Nacional de Planeación *La Revolución Pacífica*, 1991.

<sup>7</sup> Headed at the time by Navarro, a member of the former guerrilla group M-19.

<sup>8</sup> It is important to note that, despite the fact that the MOH is formally the head of the health sector, this agency was unable to exercise leadership in the debate that was taking place within government.

<sup>9</sup> There were also complete proposals the University of Antioquia (1991), the Olof Palme Corporation (1991) and Fedesarrollo (1991).

<sup>10</sup> See press coverage 1991 – 1992 with particular emphasis on the newspaper *El Tiempo*.

<sup>11</sup> Decree 2148, 1998 mandated the reform of the ISS; decree 2164 mandated the reform of the Ministry of Health; decree 3174 mandated the reform of the Health Superintendence and the other public social security institutions.

<sup>12</sup> Pensions reform was seen as a mechanism that could boost internal savings and thus give more stability to the country's economy in the long run.

<sup>13</sup> This last position was defended by senators like Jaime Arias, a Conservative member of Congress who was a doctor with a political base in the sector and with a particular interest in public health issues.

<sup>14</sup> Influenced by the Ecuadorian system, the team suggested that both insurance plans should offer the same services within a certain number of years after the reform's implementation (Interview, 07/27/98)

<sup>15</sup> This health service scheme was based on an experience President Gaviria had seen in Southeast Asia and was favoured by De Roux, the Minister of Health and the rest of the M-19 party.

<sup>16</sup> Gustavo De Roux resigned accompanying the M-19's decision to break from the political coalition that supported the Gaviria administration. See *El Tiempo*, November - December, 1992 issues.

<sup>17</sup> This team was soon joined by Nelcy Paredes, who had been working on the Hatogrande proposal.

<sup>18</sup> At this stage, these state-society networks also proved valuable to help the team find and recruit the very scarce technically trained personnel the team needed to develop the health reform proposal in detail.

<sup>19</sup> Discussions mainly centred around the content of the basic health care package (POS), and the funding for the subsidised health plan. The government, some members of Congress and actors from the private sector advocated a flexible POS whose content should be adjusted and if necessary reduced, according to the available resources. However, the final decision moved towards the inclusion of every level of attention and every risk, as was provided for – if only on paper – by the ISS according to Decree-Law 1650, 1977. At the end, a single POS for all was approved, along with the progressive expansion of coverage of the subsidised health plan's basic health care package, until both health plans would offer the same POS.

The ISS' role and its functions were also discussed during those sessions, particularly whether it should be decentralized or even dismantled. The Minister of Finance (Rudolph Hommes) as well as the Chairman of the Legislative Commission (Fernando Botero) thought that should be the case. Countering this position were some members of Congress, including some liberals, leftist parties and civil movements; unions and the group from the ISS-Consenso. At the end, the ISS

was not dismantled and was even left in a stronger political position after the congressional debates.

<sup>20</sup> According to people working in the Ministry at the time, the law development process focused mainly on technical issues such as the creation of the CNSSS; definition of the new providers who were to operate in the health system such as EPS, IPS, public hospitals – in their new role - ESS and FOSYGA; the definition of the system's benefits through the POS, complementary plans and the subsidised health plan; reforming public institutions such as the Ministry of Health and the Health Superintendence.

<sup>21</sup> Gonzalez Posso was the second Minister of Health during the Gaviria administration in early 1992, and was a member of the M-19, but not a former guerrilla member.

<sup>22</sup> Nelcy Paredes and Beatriz Londoño.

<sup>23</sup> Local governments of the affluent regions and some cities had the capacity to absorb and profit from the policy changes brought about by the reform. But other regional and local level governments which did not count on the human capital necessary to assume the responsibility of health policy and which were uncertain about the new resource allocation system, were less willing to assume autonomy in health policy-making. See La Forgia, 1994.

<sup>24</sup> Alonso Gómez (who stayed for one year); Augusto Galán Sarmiento (six months) and María Teresa Forero de Sade (two and a half years).

<sup>25</sup> He was Samper's personal doctor, and former director of Hospital San Jose, a public hospital in Bogota. A psychoanalyst by training, he met Samper when working in the intensive care section where Samper was treated after he had suffered an assassination attempt in the 1980s.

<sup>26</sup> For instance, in his new position, he promoted the creation of the presidential Program for Hospital Development, based on principles contrary to the reform such as state responsibility, and in clear contradiction to ministerial and local authority and autonomy.

<sup>27</sup> A cardiologist, he was involved in private practice and worked in a prestigious private clinic in Bogotá (Clinica Maio).

<sup>28</sup> He is the brother of Luis Carlos Galán Sarmiento, the founder of this faction and a Liberal leader and presidential candidate assassinated in August 1989.

<sup>29</sup> He resigned when allegations surfaced that President Samper had accepted drug money to fund part of his presidential campaign.

<sup>30</sup> In which Galán Sarmiento wanted to leave his imprint in the health sector, instead of just playing an instrumental role in Samper's coalition building.

<sup>31</sup> Fedesarrollo, 1995.

<sup>32</sup> A doctor specialised in paediatrics, she had previous experience in the public sector, and had held a cabinet post before.

<sup>33</sup> Public funds to FOSYGA (the new health system's national fund) which had been secured in the new Law, were instead conditioned by the government's fiscal policy at the macro level, and thus became unreliable. The fund was further crippled by evasion and under-reporting on the contributory health plan

<sup>34</sup> Ministerio de Salud. Informe de Actividades 1997-1998 al Honorable Congreso de la República, Julio 1998, Bogotá.

<sup>35</sup> 20 private, 10 public and 1 public/private

## **Chapter 4. The Change Team and its Strategy Choice**

### **4.1 Introduction**

As in other sectors where the Gaviria administration had a reform agenda, a group of policy-makers foreign to the Ministry of Health and with expertise in economics was assigned the responsibility of formulating a health reform and was empowered to lead it. The health change team was created upon the appointment of Juan Luis Londoño as Health Minister in November 1992, and was to last until the end of the Gaviria administration in August 1994. During those eighteen months, the health change team formulated the reform proposal, negotiated its legislation, formulated the new Law's regulation package and prepared its implementation.

This chapter analyses the health change team. It describes its characteristics and looks into the profile of its members in order to bring to light the shared skills and policy experience which it counted on to pursue the health reform. It then looks into the team's ideological profile and how this reflected their policy choices as well as the political strategies it resorted to. Next, the series of policy networks the team built and resorted to as a means to embed itself within the state are described and analysed. Finally, the team's choice of political strategies are analysed in the light of the political context in which they were made and the policy process they were to buttress.

### **4.2 Change Team Characteristics**

The health change team was created in November 1992 by Juan Luis Londoño, when President Gaviria appointed him Minister of Health. Londoño appointed highly trained young professionals from within and outside the public sector, but who, with very few exceptions, were new to the Ministry of Health. The team's overall composition changed as the reform process evolved, but it sustained throughout the reform process a combination of skills that emphasised an

economic perspective and the use of changes in regulation in guiding its policy choice.

The health change team became clearly identifiable during the reform's formulation and its presentation for approval in Congress. At this time, Londoño and other members of the team built an important network of support around the reform and the team itself with key members of Congress, the Executive, and other groups in and outside the state. The fact that some of the team members' previous positions had been as DNP officials, gave the team credibility vis-à-vis other policy-makers working on similar state reforms, and crucially vis-à-vis the economic team in government.

Juan Luis Londoño studied Business Administration and obtained a Masters in economics in Colombia before earning his PhD in Economics from Harvard University<sup>1</sup>. Soon after returning to Colombia, he joined the government's economic team when President Gaviria appointed him to the DNP, where he became deputy director in August 1990. He was later appointed minister of the MOH, where he stayed until the end of the Gaviria administration<sup>2</sup>. He was the team's undisputed leader, taking final decisions when there was disagreement among team members, and the reform's principal broker within the Executive, in Congress, and in society.

He also played a crucial role in absorbing the ideas on health reform that were being discussed in the international health policy community, and "tropicalising" them to the Colombian context<sup>3</sup>. During his graduate studies at Harvard, and later on in his position as DNP deputy director, he became acquainted with international social policy trends, and particularly with the background work for the World Bank's World Development Report (1993) that focused on health reform. Once appointed Minister of Health, he approached international experts like Julio Frenk and Philip Musgrove, national health specialists such as Francisco José Yepes and Iván Jaramillo and groups with experience in health issues working in the private sector to learn and discuss the health sector's policy issues.

When he was assigned the formulation of the health reform, Londoño put together a change team at the MOH, whose members, instead of holding formal positions in the MOH's structure, worked directly with him in the form of a task force. The core members of this health change team were Nelcy Paredes, Maria Luisa Escobar, Beatriz Londoño, Oscar Emilio Guerra, Teresa Tono and Edgar González. Other members included Wolfgang Munar, Eduardo Alvarado, Iván Jaramillo and Diego Palacios. This group was recognised as the health change team by its members and by outsiders, both at the Ministry and elsewhere in the government. More than half of them did not have any previous public policy experience and were not considering a career within the government prior to joining this effort.

Notwithstanding, the sum of each member's particular skills and professional experience endowed the team with the technical and political tools to formulate the health reform and to negotiate its legislation and eventual implementation. While core team members did not vary significantly following different demands at each stage of the reform process, their level of influence in the team's decision-making did. This reflected the constant tension between the need for highly technical detail in the reform's policy content, and the simultaneous need for policy negotiation and consensus-building with other actors in the sector. For instance, during the formulation of the reform's regulation package, technical decision-making was prioritised, but this same emphasis on technical aspects was given a secondary role and even perceived as a hurdle during the team's efforts to ensure the political survival of the reform just before they were going to leave office.

A salient example of the combination of these skills put to work are the contrasting roles of Nelcy Paredes and Maria Luisa Escobar, both members of the health change team. Nelcy Paredes, an economist, was Londoño's second in command throughout the reform process<sup>4</sup>. Having been head of the Health Division at DNP for almost a decade from the 1980's to the early 1990's, she

brought with her key knowledge of the health sector as well as its actors. Her command of knowledge and information about the health sector in Colombia combined with her ability to communicate on a one-to-one basis with actors involved in both high and low-level positions of responsibility, made her play a strategic role as broker for the team's technocrats (Interview, 07/10/98). She won the trust of and was involved in direct negotiations with mid-level and senior officials in the Executive, legislators in Congress, and leaders of societal groups involved in the reform process, and working on many occasions as a ground-breaker for Londoño (Interview 07/10/98).

Being aware that the health reform's feasibility was based as much on its technical viability as on the political dynamics of its process, she was willing to compromise policy content as a strategy to ensure the overall survival of the reform. This sometimes put her at odds with the technical members of the team. She was the only member of the change team who was to remain at the MOH for most of the Samper administration, from where she continued her efforts to ensure the consolidation of the health reform<sup>5</sup>.

In a mirror image of Paredes, Maria Luisa Escobar, also an economist, was an orthodox technician. She was working at the Inter-American Development Bank in Washington when she was recruited by Wolfgang Munar – then Deputy Health Minister. Even before the reform initiative was approved in Congress and political negotiations were taking place, she started to conduct highly specialised studies based on the team's reform agenda anticipating the requirements to define the reform's regulation package. Upon her arrival at the MOH, she put together a large team of very young economists who concentrated on the most complex and technical aspects of the reform.

She and her aids worked in complete isolation from other change team members, the MOH bureaucracy and interest groups in society. She defined elements central to the reform's implementation, such as the content of the Benefits Package (POS) – for which she conducted the costing and DALY's analysis. During the process



of reform formulation and legislation, her authoritative knowledge of health microeconomics and her technical penchant made her instrumental in supporting the team's image as an apolitical group working exclusively on rational objective premises.

Also during this period, her expertise was also used to overload policy dialogue with a technical discourse that worked as a smoke screen for the team and the reform (Interview, 08/05/98). She firmly believed that no concessions should be made on these elements if the reform was to preserve its original nature – and objectives. So when the political dimension of the reform process pressed for concessions, her participation in decision-making was marginalised (Interview, 08/05/98)<sup>6</sup>.

Oscar Emilio Guerra and Edgar Gonzalez played a key role in converting the reform's policy content into law. Guerra, a lawyer, joined the team on the recommendation of the Deputy Finance Minister – who later became Minister of Labour. His expertise in regulation and knowledge of the law was central, given that the team's strategy to bring about policy change was based on changes in rules and regulation. He enjoyed great credibility among the members of the economic team and had experience in policy regulation of the financial sector – where he had occupied senior positions in the banking and stock market regulatory agencies.

Guerra, along with the team of lawyers he brought to work at the MOH, ensured the legal base of the team's proposals (Interview, 11/12/98)<sup>7</sup>. Gonzalez complemented this role using his expertise in public administration, with particular emphasis on the health sector. He was instrumental first, during congressional discussions around the reform, and later, on the formulation of the regulatory package once the reform had been legislated. He was the only member of the change team that had an appointed position at the MOH before the team's arrival, and while not entirely in disagreement, he did not share the team's ideology (Interview, 10/11/98)<sup>8</sup>.

Following in importance, were Teresa Tono and Beatriz Londoño, both doctors with graduate studies in the US. They both had had research-based careers in academia abroad and Colombian think-tanks. While Teresa Tono participated in the institutional development aspect of the regulation package, Beatriz Londoño played an increasingly important role as the articulator of the team's agenda towards public opinion. The fact that she was a doctor helped the team to soften its image as outsiders in the sector and to bridge links with the medical profession, which acknowledged her "hands-on" experience.

She was one of the most visible members of the team, since aside from participating in policy formulation, she was in charge of public relations and appearances in the mass media (Interview, 07/10/98). Close to the outset of the Samper administration, Beatriz Londoño became Health Secretary of Bogota, becoming the only member of the health team to have the opportunity to pursue the reform process into its implementation stage. Using a change team strategy as well, she was able to bring about significant policy change<sup>9</sup>.

Finally, although not part of the core group forming the change team, Diego Palacios was instrumental in developing the media campaign geared to buttressing public opinion's support for the reform – and by the same token, for the change team. He was a doctor who had studied public health and communications. He developed a media strategy by which a series of public health topics – such as AIDS – were presented on T.V. and radio and in the press as a means to introduce the health reform issue to public opinion and thus build support around it.

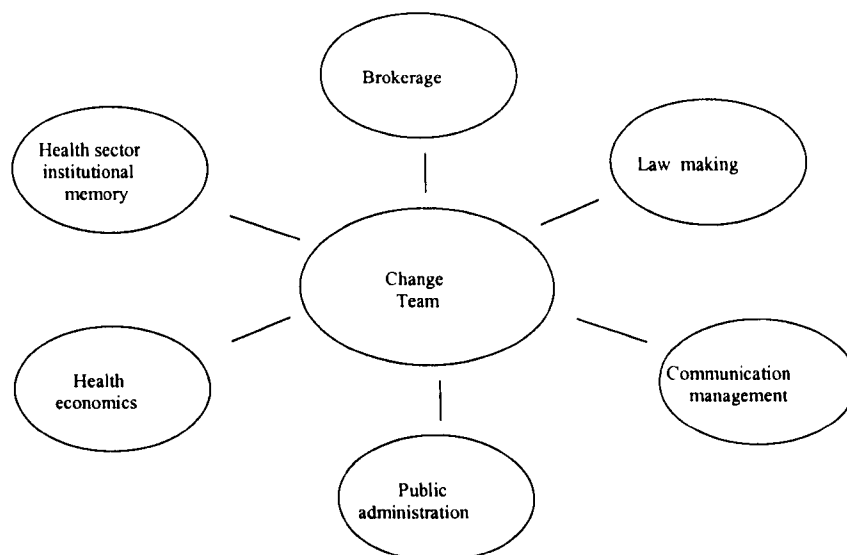
The policy-makers and technical professionals described above endowed the change team with an array of policy and political skills that went beyond its members' technical expertise. Thanks to this, the team was able to tap the knowledge about the health sector in Colombia and its actors, and the intricacies of public administration. It also counted on the expertise needed in the area of lawmaking, as well as media management. Team members adjusted to the

requirements of the health reform process by emphasising at times some of its members' skills in political manoeuvring and brokerage, while at others, other members' highly technical command of the reform's policy content.

Figure (4.1) presents a diagram representation of the mix of skills with which the change team was endowed as a result of the professional profiles of its members.

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**Figure 4.1: Change Team's Mix of skills**



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### **4.3 Change Team Ideology and Perception of State-Society Relations**

The health change team had a cohesive view about the importance of introducing market mechanisms to make the health sector more efficient and de-politicise resource allocation within it (Interview, 11/12/98). This ideological position was in tune with that of the economic team and President Gaviria himself. However, within the change team, some division persisted between those in favour of a stronger public health sector versus those in favour of the market as the main mechanism for regulating the sector and an enhanced role for the private sector in health service provision. Under Londoño's arbitrage, the latter position prevailed.

However, this should not be mistaken for an orthodox neo-liberal stand. Londoño believed in the benefits of market competition as much as in the need for its effective regulation. Also, more than any one of his peers in the economic team,

he strongly believed in the need for investing in Colombia's human capital as part of the policy to promote economic development - and as an end in itself<sup>90</sup>. Still, in line with the Gaviria administration's ideology, he saw demand subsidies, a greater role for the private sector, competition mechanisms and targeting of social programs as the means to pursue these policy objectives.

The team perceived state-centred service delivery and regulation not only as inefficient, but as serving vested interests. Therefore, the team viewed with suspicion arguments pointing at the country's limited institutional capacity to absorb policy change as a justification to avoid comprehensive and in-depth change. Along that line, the sector's old providers – such as the ISS, the MOH and local authorities, among others – should be forced into action by the imminence – and inevitability – of the policy change brought about by the reform, and by the effects of market competition it intended to put in motion. From this standpoint, the team systematically thought about the policy results it wanted to attain with the reform, and systematically avoided considering the limitations its implementation would face (Interview, 11/12/98).

However, within the restricted space of technical discussions, team members did ponder the applicability of international experiences in the Colombian context, and the feasibility of implementing certain elements of the reform given the country's institutional capacity. Notably, discussions did address the viability of inducing policy change solely through changes in legislation and regulation (Interview, 05/11/98b). But technical arguments were seen as superior and more legitimate than political considerations, and the team stood firmly behind the belief that it was possible to “modernise” the country through the technocratic strategy the economic team in power had chosen (Interview, 05/11/98b).

This emphasis on technical criteria to the detriment of political considerations, and the team's self-perception as apolitical – thus with no personal agenda behind the reform – made it consider that it had the moral ground to decide what was best for the country. Team members saw consensus-building efforts and participation with

suspicion and therefore to be conducted only when institutional rules required it – as when submitting the reform initiative to legislation, but not when formulating its regulation package. The team believed that organised vested interests took these “openings” in an otherwise insulated process as opportunities to resist change or to influence policy-making in their favour, and that the reform risked putting its central elements – notably equity and efficiency – in jeopardy (Interview, 08/05/98). Also, in their view consensus-building was difficult to put into practice, since the members of very few societal groups felt represented by its leadership, rendering consulting the latter a useless process (Interview, 11/12/98).

#### **4.4 Change Team Political Manoeuvring**

Team members did not have any personal political support or power base outside the Executive, therefore the political feasibility of their reform agenda and of their leading position in the reform process depended exclusively on the support of the president and the government’s economic team (vertical networks). This fact shielded them from political pressure from outside the Executive – and from other government factions within it. But not having a social mandate or a particular coalition of support made them entirely dependent on changes in the economic team’s – or the president’s – policy priorities. Once given the political backing to lead the reform (vertical networks), the team’s brokers – notably Londoño and Paredes – made a systematic effort to embed the team within the state (horizontal networks) and provide it with information, knowledge and specific help from other actors in Congress and society (state-society networks).

##### **4.4.1 Vertical Networks**

The president’s and the economic team’s support for the health change team was based on two grounds. First, the fact that once taken on board, the health reform initiative became part of the government’s agenda on a par with the pensions reform. Second, the fact that Londoño was a member of the economic team, which effectively converted the health team into an extension of the former. The change

team's main vertical networks were thus President Gaviria, Finance Minister Hommes, and DNP Director Montenegro, whose direct support empowered the team and shielded it from inter-agency and bureaucratic competition and external political pressure. The backing of these senior officials and the president also gave the team enough political weight to confront resistance to change in the different policy nodes where the reform process took place.

Both Hommes and Montenegro viewed the health change team's reform initiative as an opportunity to transform the health sector and make it more efficient. Given that Londoño had participated in the economic reforms as a member of their team, they saw in him an equal not only in training, but also in ideological stand. This relationship and their sharing of the same technical language gave the health change team the capacity to make its case in favour of the reform and prove its financial soundness based on direct and authoritative knowledge of public finances and the potential economic impact of the proposal.

But ultimately, in spite the fact that the health reform had not been part of his original reform agenda, it was President Gaviria's direct support that proved to be the most crucial vertical network. He intervened directly to back the change team at least on three occasions that proved to be critical for the reform's survival – and showed the importance of his role and that of the other two vertical networks. First, when all other instances of negotiation were exhausted during the reform's legislation process, President Gaviria resorted to Colombia's inter-party elite negotiation and summoned the leaders of both traditional parties to reach an agreement that secured enough votes to approve the bill (Interview, 08/23/98).

Second, once the Law had been approved and the details for its implementation were being prepared, he ensured that the economic team's faltering support was held firmly behind the health team. When the health team moved on to secure public resources to cover the reform's transition costs, and focused on ensuring the rapid expansion of the newly mandatory access to health care – while failing to limit the basic health care package (POS) – the economic team became

concerned about the fiscal impact of the health reform. Both Hommes and Montenegro balked at their support – with the latter taking action to limit the change team’s efforts.

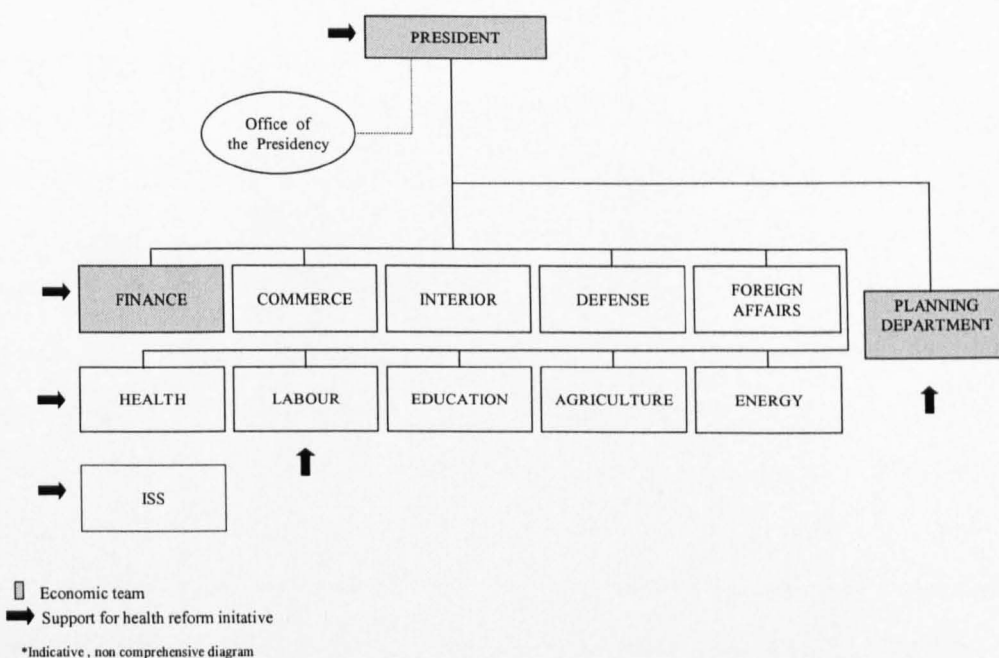
The curtailing of these two vertical networks meant the sudden halt of the reform on the grounds that sound fiscal policy was a higher priority on the government’s agenda. However, President Gaviria stepped in to secure the support of both officials in favour of the health change team, in view of the reform’s visibility and positive political impact.

Thirdly, President Gaviria resorted to his prerogatives as head of the Executive and during his last days in office, he signed a series of executive decrees – prepared at frantic speed by the change team. By using this institutional mechanism, and resorting to this strategy, President Gaviria maintained the definition of the reform’s details insulated from public scrutiny – thus averting resistance to policy change – and sped up the reform process in an effort to ensure its implementation and consolidation in the following administrations<sup>11</sup>.

Figure (4.2) shows the principal points within government from where the sources of support for the health reform initiative stemmed. Members of the economic team – located in government agencies marked in grey – formed the change team’s vertical networks. Support stemming from within the MOH, from the team appointed by President Gaviria at the ISS, and from the Ministry of Labour, represent the health change team’s principal horizontal networks – which will be analysed next.



Figure 4.2: Health Reform Initiative: Sources of Support \*



#### 4.4.2 Horizontal Networks

Once counting on the support of its vertical networks, the health change team actively sought to embed itself within the state by strengthening its horizontal networks and building new ones with like-minded public officials with a similar hierarchical level. These horizontal networks helped the team negotiate the reform at the different stages of its process – notably during legislation – facilitated communication and information exchange at the right time among peers, and were also used in an attempt to institutionalise the reform within the MOH proper.

In the case of the Labour Ministry and the pensions change team, the fact that the health reform initiative was presented in Congress as an addendum to the pensions reform gave the health team the opportunity to join efforts – and political leverage – with these policy-makers. The change team thus strengthened ties with the

pensions change team – which was also working in close co-ordination with the economic team – and jointly prepared strategies in aspects relevant to the health reform. Therefore, the health change team mounted its political strategy in Congress profiting as far as possible from the advances made by the pensions team, and reducing its political manoeuvring to those instances that were particular to the health reform<sup>12</sup> (Interview, 08/23/98).

In the case of the DNP, although its relevance in the health reform's policy formulation greatly diminished when its senior officials working on the issue were assigned to the MOH, the junior officers who stayed behind continued to maintain informal ties with their former project leaders. Through this horizontal network, the health change team had access to the DNP's policy studies, background material and relevant information that helped it both in policy formulation, and in enhancing its leverage during negotiations within the Executive and in Congress. Although these horizontal networks were intermittent and were enhanced or suppressed at different stages of the reform, it could be argued that the Social Policy Division within the DNP acted as a "back office" to the health change team effectively expanding its policy-making capacity (Interview, 11/03/98).

Two examples point to this fact. First, while at the DNP, Londoño had promoted the formation of a policy group called Misión Social formed by highly trained officials who were relieved from everyday operations at the DNP and focused exclusively on policy research to support decision-making<sup>13</sup>. After Londoño left the DNP, this group continued to support the health change team, along with officers heading the Health Division. Second, the health change team made extensive use of a targeting mechanism for social programs that was being developed in the DNP – called SISBEN – as a tool to develop the implementation of the reform's subsidised health plan directed at the poor.

As regards the ISS, it cannot be argued that there was extensive co-ordination in policy-making between the health change team and ISS officials. In fact, both agencies pursued their transformation in separate parallel processes. However, the

change team did establish horizontal policy networks with like-minded officials at the ISS directorate who supported both the pensions and the health reform, and shared the same ideology and technical language.

This was made possible once President Gaviria had replaced the ISS directorate that resisted change with officials stemming from the core economic ministries more in line with the government's policy agenda. Thus these ISS officials and the health change team co-ordinated those aspects of the ISS transformation that were relevant to the health reform, and joined efforts in lobbying for the pensions-health bill in Congress. These horizontal networks played an important role in maintaining unity within the Executive and presenting a common front vis-à-vis other groups resisting change.

The change team created a series of horizontal networks within the MOH with a mix of new and old MOH officials, thus creating a "pocket of efficiency" (Geddes, 1994) within the MOH that streamlined key activities in support of the change team's endeavours. This allowed the change team to embed itself within the MOH and tap into the inputs it needed to operate – such as information, knowledge and support activities, among others – sidelining major segments of the MOH's bureaucracy. To do this, Londoño seized the opportunity of a major transformation of the MOH taking place in late 1992 as part of the government's broad institutional reform agenda and replaced most of the MOH directors with like-minded officials<sup>14</sup>.

Simultaneously, after carefully studying their professional profiles, the change team selectively approached officials who were already working at the MOH and who were willing to co-operate with the reform initiative. In contrast to the officials who were removed – or whose assignments were changed – the officials who thus made up these horizontal networks supporting the change team were young, highly trained and believed that policy change was possible. A few examples were the MOH General Secretary in charge of overseeing the MOH's reform and its decentralisation, the directors in charge of the Public Health

Division and the Promotion and Prevention Division, and notably, the liaison personnel for international co-operation, since the latter proved key for the change team efforts.

The change team also intended to use these horizontal networks as a long-term strategy aimed at institutionalising the health reform within the MOH and ensure its continuity beyond its tenure in office<sup>5</sup>. However, while the creation of this pocket of efficiency was effective in its short-term purpose of giving support to the change team, and most of its members did stay in office during the Samper administration, its *modus operandi* – particularly the fact that it operated independently from the MOH bureaucracy – precluded it from institutionalising the reform more broadly within the MOH bureaucracy, which did not assume ownership of the reform initiative (Interview, 11/12/98).

#### **4.4.3 State-Society Networks**

Along with its efforts to secure political support (vertical networks) and to embed itself within the state (horizontal networks), the health change team established selective state-society networks with groups and actors outside the state in order to obtain relevant information and knowledge, and ultimately to fine-tune the reform using the experience these organisations had – particularly in the private health sector. These state-society networks varied according to each stage of the reform process. During the reform formulation stage the main networks were with academia and international organisations; during the reform's legislation the main networks were with legislators; and during the formulation of the regulation package the main networks were with private health organisations. Finally, the change team attempted to establish networks with policy-makers who were going to be put in charge of the reform in the incoming administration.

As soon as the health change team was formed, it strengthened the networks that some of its members – notably Londoño and Paredes – had established with academia, think tanks and NGO's that had been studying the health issue and had

been involved in the national policy dialogue around health reform that started in the early 1990's<sup>16</sup>. The team thus obtained first-hand information and knowledge through what it saw as an informal training process. Some examples of these networks at the time of reform formulation were Metrosalud and the FES Foundation of Leadership. However, while these experts were consulted for advice and information, they were not invited to join the change team or to participate in policy formulation and decision-making. Their level of influence over the reform's content was limited to the change team's criteria.

During the reform's legislation process in Congress, the change team built networks with key legislators and their advisors who brokered the reform among their peers, and were key in teaching the change team the insiders' knowledge of political manoeuvring within Congress. Two legislators stand out as examples. The first and most important one was Alvaro Uribe Vélez. A Liberal identified with a rival faction to that of President Gaviria's – Samper's faction – he was nonetheless sympathetic to the technocratic reforms pursued by the Gaviria administration and had a particular interest in the health reform. He was in charge of presenting the social security bill in Congress<sup>17</sup>. Uribe Vélez had also been in charge of presenting the labour reform initiative in 1990, and therefore was acquainted with the economic team and its "extensions" now working on the health and pensions reforms. A traditional politician, he had studied at Harvard and was a strategic ally for the change team since he had a long successful record of political negotiation, but at the same time was able to rely to the highly technical discourse of the change team. Another important network in Congress was Victor Renan Barco, who was also a traditional politician, but who had played a key role in economic legislation, and was also able to bridge the gap between the change team and the legislators<sup>18</sup>.

From a different standpoint, the health change team was also able to approach members of the *Alianza Democrática* movement – related to former guerrilla movement M19 – who were part of the Congressional Commission debating the health reform. It did so through the network it had maintained with former MOH

advisor Ivan Jaramillo, who helped “bridge” the interaction between these legislators and the change team, in spite of the fact that the M-19 had left the government’s coalition. Jaramillo did not share the change team’s ideological position, but had been involved in the discussions on health reform since the start. After the departure of Health Minister Navarro – a former leader of the M-19 – Jaramillo continued to work on several aspects of the health reform – particularly related to the health system’s decentralisation and Law 60, 1993 – and thus remained in contact with the change team.

Once the reform had been approved in Congress and gravitated back to the Executive’s control, the change team modified its state-society networks once more and significantly reduced them, opting back for the insulation strategy. According to an interviewee, only those actors who shared the change team’s ideas remained in touch with it (Interview, 07/27/98). Thus the change team selectively – and intermittently – reached out for actors in society who had information or knowledge relevant to the health reform, or who were to have an important role in the new health system<sup>19</sup>. These state-society networks seldom evolved into a policy dialogue where the health change team and these groups would discuss policy content on equal terms. Instead, the change team tightly controlled these groups’ access to policy formulation opening and closing the door to the decision-making room according to its own agenda.

This did not preclude the societal actors who were contacted from trying to use these state-society networks as a means to make their case and influence policy formulation in their favour, and there does not seem to be consensus as to how successful they were and the degree of influence they had. Such was the case of the private health insurance companies that approached change team members to make their case for a lax regulation package (Interview, 11/03/98).

## **4.5 Change Team Choice of Strategies**

The change team chose a series of strategies aimed at both securing its position of influence throughout the policy process and also, as a result, enabling it to promote its reform agenda. Those strategies changed according to the stage of the reform process and were not made in a vacuum but instead responded to the opportunities and limitations of the political context in which the reform process was taking place. Some of them defined the interaction between the change team and other actors involved in the reform process, while others altered the reform's policy content as a means to ensure its political feasibility. Finally, while some strategies focused on solving short-term bottlenecks or resistance to change, others were aimed at enhancing the reform's chances of consolidation in the long term.

Some of the team members pointed to the speed at which it was constrained to operate to justify the choices of strategy it made – such as the choice of comprehensive change, as opposed to incremental change; and the minimum level of policy dialogue – or insulation (Interview, 11/12/98). While it is undeniable that the team had a very short time frame in which to act – only eighteen months – it can also be stated that their strategy choice was coherent with their ideology, as well as their view of the role of the state and of state-society relations. In other words, their choice of strategies can be related back to their perceived need to bring about major policy change in the short run, and their view of the relation between arguments against the reform and entrenched interests resisting change.

### **4.5.1 Speed and Scope of Policy Change**

Thus, when formulating the reform, and in view of the scarcity of time, but also as a means to avoid organised resistance to policy change, the change team chose to avoid an incremental, trial-and-error approach and pilot projects to verify the applicability of the reform before its implementation on a major scale. Instead, it opted for assuming the risks – and absorbing the costs - related to in-depth fast

change that bore little consideration for the complexities of its implementation and the involved actors' uneven capacity to absorb it. Thus the team's strategy can be described as one that transferred the learning process to the implementation stage in order to avoid marring the reform at its formulation stage. Also, foreseeing the possibility that resistance would mount once the team left office – and the reform entered its implementation stage during the Samper administration – it focused on advancing the reform as far as possible to increase the costs of redressing it once it lost control over it (Interview, 07/10/98).

#### **4.5.2 Brokerage in Congress**

During legislation, the change team's overall strategy choice was to broker the health reform under the umbrella of the major social security reform project in a sort of "division of labour" by which it left as many aspects of the political manoeuvring as possible in the hands of the pensions team. In doing so, it was able to preserve its image as a technical apolitical group<sup>20</sup> and to negotiate the health reform away from the limelight. But in spite of the fact that most of public opinion's attention and political negotiation centred on the pensions reform, the health change team still needed to lobby the aspects that were particular to the health reform.

Thus, relying on the Executive's active participation in promoting the social security reform, and based on its perception of congressional politics, the team chose a strategy of targeted brokerage, instead of broad coalition-building. The health team's assessment of Congress was one in which the majority of legislators were disengaged with respect to the health reform issue, and thus ready to "follow" the vote of the minority groups that were directly involved with it and thus could potentially veto the reform (Interview, 08/08/98). These minority groups, which were thus crucial for the reform's approval, were perceived by the change team as having to two extreme positions.



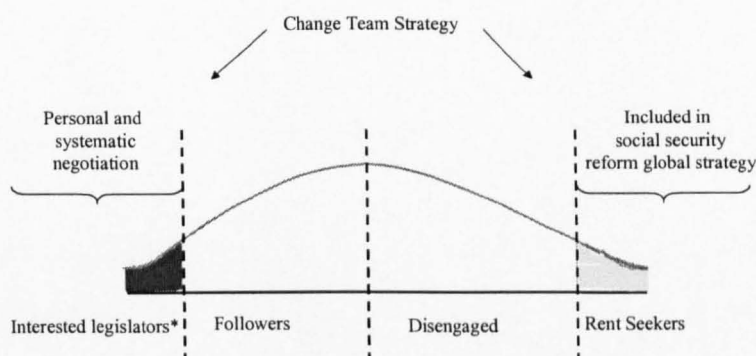
The first group was made up of the legislators in charge of analysing the reform at the Social Affairs Congressional Commission and a few congressmen who had a particular interest in the health reform. The legislators in this group departed from positions for and against the reform based on their ideological stand and/or their alliances with societal groups for or against the reform – as was the case of pro-labour legislators who were against the reform because it affected the provider union's interests. For this group, the change team's strategy was to single them out and lobby them individually, engaging them in a policy dialogue on a one-to-one basis over the entire legislative period. The team made a point of listening to – if not of incorporating – all the queries and suggestions these legislators made, and focused on explaining the complex issues that lay behind the different elements of the reform.

At the other extreme, the change team perceived a group of legislators who did not have a position vis-à-vis the health reform, but instead engaged in patronage and Congress' parochial politics, thus conditioning their vote to favourable conditions for their constituencies. The health team's strategy towards this group was twofold: on the one hand, the team relinquished direct political bargaining as much as possible, and instead relied on the Executive's direct negotiation on behalf of the social security reform – mostly through the pensions team, but also through the direct intervention of the president. On the other, the team phased the reform's implementation in a way that it would produce visible results in the regions these legislators represented, thus creating the political incentives for them to support the reform<sup>21</sup> (Interview, 05/18/98).

Figure (4.3) presents a diagram of the composition of Congress in the light of the health reform initiative as perceived by the change team, and its choice of strategy to broker the reform with each group.

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**Figure 4.3: Change Team Assessment of Congress**



\* Legislative Commissions

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### 4.5.3 Choice of Legislation

Another key strategy choice made by the change team was to draft a reform bill based on broad general terms and the common ground principles that had been agreed on during the National Constituent Assembly – equity, efficiency and solidarity. This eluded interest confrontation and greatly reduced the need for policy negotiation, since all parties saw their positions reflected in these general principles, and the potential overlap in the requirement to apply them was not made evident, given the lack of detail on how they would be implemented.

This strategy of having a law based on general principles approved, also gave the change team more space for manoeuvre in defining the reform's final policy content, since the definition of policy details forsaken during legislation was postponed to happen during the formulation of the reform's regulation package – which was a prerogative of the Executive.

However, while in the short term this strategy proved useful in legislating the reform – and ultimately in enhancing the team’s control over its content – it proved to hamper its potential for consolidation in the long run, since the very lax terms of the new Law left room for further modifications made by other governments in charge of the reform’s implementation.

#### **4.5.4 Policy Dialogue**

Particular emphasis needs to be placed on the change team’s choices when determining other actors’ access to the reform process and therefore their influence on policy content: The strategy of insulation. Based on its views about state-society relations, the change team’s first choice was to insulate itself and the reform from the influence of other actors in order to avoid vested-interest pressure. While some interviewees pointed at the lack of time as one of the reasons for the team’s restricted engagement in policy dialogue (Interview, 11/12/98), the fact that the team chose to “open” the process to other actors at certain stages of the reform and “close” it at others, in spite of facing sustained time constraints, points to a strategy choice.

The team’s capacity to insulate itself and the reform from other actors trying to influence its content depended on two elements. First, the political backing of its vertical networks, which gave it the leverage to determine when and with whom to engage in policy dialogue. Second, the institutional context in which the team had to operate following the reform process. In other words, the formal and informal rules of the game of political competition and policy negotiation of Colombia’s political context. Thus, having been empowered to lead the health reform process by the president and the economic team, the health team “opened up” only when forced by institutional requirements, or when it needed knowledge and information to pursue the health reform.

Three stages of the reform process – formulation, legislation and preparation of the regulatory package – exemplify the team’s strategy choice in determining the

degree of insulation around the reform. When recently appointed, the team chose to “open” the process to a wide variety of actors with whom it established state-society networks and participated in policy debate as part of its learning process. But at the moment of reform formulation – i.e. the preparation of the bill to be presented in Congress – the team chose to insulate itself and policy decision-making was conducted exclusively among the team’s members, in spite of the efforts of these actors to participate (Interview, 11/03/98).

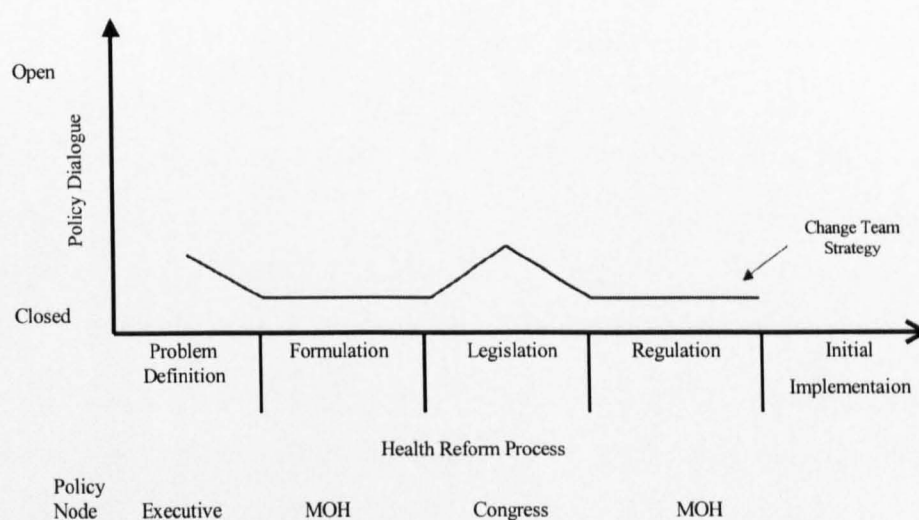
During reform legislation, the team was forced to “open up” again by institutional requirements and to engage in pro forma consultation exercises with every visible head of the groups interested on the health reform, such as unions, doctors, business associations, pre-paid medicine organisations, and academic forums, among others. However, the change team approached this requirement more as an exercise of information dissemination, than one of policy dialogue, and did not alter the reform’s content as a result of the debates. Furthermore, the change team’s ideological position to constrain policy debate to technical argumentation precluded many actors participating in the consultation exercises from understanding what was at stake<sup>22</sup>.

Once the reform was legislated and given that the institutional rules made the formulation of its regulation package a prerogative of the Executive, the team’s need to resort to consultation and policy dialogue ceased, and it chose to insulate itself once more. Thus, with the leverage to resist interest-group pressure, it carefully selected the actors with whom it established state-society networks based on its needs for knowledge and information in the preparation of the reform’s regulation (Interview, 11/03/98).

Figure (4.4) presents a diagram with the change team’s choice of strategy over policy dialogue. The horizontal axis presents the different stages of the reform process. The vertical axis represent the choice of policy dialogue from closed or non existent (insulation), to open or inviting participation (consensus building). The line presents the team’s choice at each stage. The closer the line is to the

horizontal axis, the less policy dialogue and thus the more insulated the change team. The diagram shows that the change team chose a strategy other than insulation only during two stages: First, during the definition of the health sector's problems and second, during the reform legislation. In both stages, the institutional context forced the team to abandon the insulation strategy and engage in policy dialogue to broker the reform.

**Figure 4.4: Change Team's Strategy Choice on Policy Dialogue**



#### 4.5.5 Transition Strategies

With the end of its tenure in office in sight, and aware that under the incoming administration the health reform would be under the control of the government faction that had opposed it during its formulation, the health change team sought to enhance the chances of the reform's implementation and consolidation. The strategies it chose for this purpose were permeated by its ideology, as well as its members' previous policy experience in economic reform. Three of its choices exemplify this. First, as has been discussed, the team focused on formulating

detailed regulation as a means to produce – and ensure – change through modifications in the rules and incentives that actors in the health sector would have to abide by.

Second, the team attempted to ensure the incoming government's commitment to policy change through the signing of loans directed at funding the reform transition<sup>23</sup>. Along with ensuring the financial viability of the reform's implementation, it expected that the terms of agreement of these loans would limit the possibility of diverting reform efforts to other directions. Simultaneously, the team sought the co-operation of international actors with no domestic vested interests and technical command over the reform content as another attempt at enhancing the reform's probabilities of being implemented as it had been envisioned<sup>24</sup>. However, both efforts to bring international actors closer to the reform process yielded mixed results, since they lacked the leverage to have influence over decisions on the reform's direction.

But the largest stakes rested on the team's relation to the incoming group of policy-makers that was to substitute it in the control of the health reform. The change team chose to approach its rival faction as a means to promote the continuation of the health reform process along the lines it had defined. The change team thus invited the new group of policy-makers to a series of meetings to discuss the technical content of the reform<sup>25</sup>. However, it simultaneously refused to allow it to participate in the team's ongoing last minute efforts to define the reform's regulation package. In other words, the change team resorted back to informing and educating about the content and benefits of its reform agenda, instead of engaging in policy dialogue on equal terms with the new group. The team's firm control over access to decision-making – i.e. its insulation strategy, which at this point reached its highest level isolating the team even from the core ministries – hampered its strategy geared to ensuring the reform's continuity and its probabilities of consolidation<sup>26</sup>.

#### **4.5.6 Inducing Change**

The change team's reform agenda was based on the implementation of two elements that were complementary conditions for the consolidation of the new health system. One was the creation of new providers in the health care system – particularly in the private sector – that would participate in health services provision, management and financing. The other was the transformation of the old providers – notably the Social Security Institute, the MOH and the local health authorities. The new health care system would be consolidated once both newly created actors and the transformed old providers were able to abide by the rules and incentives established by the new Law and its regulation. While both elements presented complex policy challenges and depended on the new and old providers' capacity to absorb and implement change, the transformation of the old providers presented, above all, a political challenge. This was particularly the case of the ISS, who resisted change protected by its strong coalition of support – such as some politicians, the ISS bureaucracy, its unions and doctors.

The change team's choice of strategy in this case was to phase out the transformation of the old providers – notably that of the ISS and to concentrate on the creation of the new providers and the rules and incentives by which they would operate. This policy choice avoided the need to impose change by directly confronting the organised provider groups opposing it. Furthermore, the change team resorted to two indirect mechanisms to bring about change in the old providers in the mid to long run. These mechanisms were based on the assumptions and the ideological stand of the change team. One was the reliance on changes in rules and regulation: the new Law mandated the transformation of the ISS and its operation under the new regulation. This was expected to be enforced during the Samper administration. The other was the market forces that were to be triggered once the new providers were created and were put in operation under the new rules and regulation: the change team expected that with the creation of new choices, consumers would opt for the best services, thus generating competition

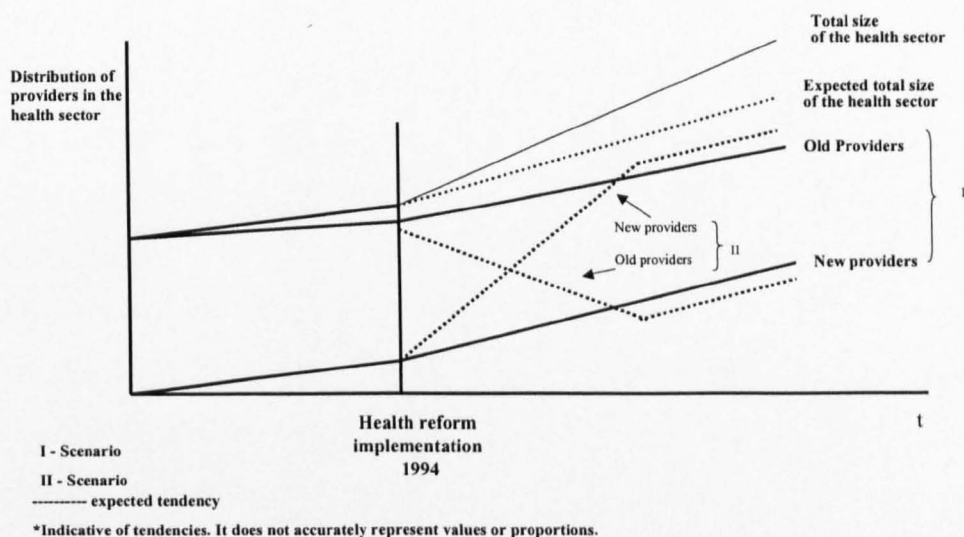
and forcing the ISS to transform itself in order to be able to compete – and survive.

Neither of these two mechanisms proved to be effective as means to trigger the transformation during the reform implementation phase. In the case of enforcing changes envisioned in the health reform and mandated by the new law, the Samper administration lacked the leverage – and the political will – to enforce it. In the case of market forces, ISS affiliates did not opt for the services of new providers in sufficient numbers to trigger competition and thus incentives for the ISS to reform. The result has been the superposition – and not the substitution - of old providers operating under old rules, and new providers operating under new rules and regulation.

Figure (4.5) shows the two scenarios for the reform's policy implementation in terms of the presence of new and old providers. The horizontal axis is an indicative time line, and the vertical axis presents the share of the health sector that each group of actors occupies – i.e their distribution. The first scenario, (presented in solid lines) describes the reform's evolution as it has occurred. New providers have emerged, but the old ones, far from losing part of their affiliates to them, have increased in size. The second scenario is the one envisioned by the change team according to the assumption that market competition would operate: new providers would emerge in the health sector and would compete to attract users previously affiliated to the old providers. A substitution effect would occur in which the old providers would diminish in size and thus their relative share of the sector would diminish as well. As a result, a more plural more competitive market would thus substitute the old health system.



**Figure 4.5: Old Providers/New Providers:  
Expected Changes in the Distribution of Health Sector Providers**



## 4.6 Summary and Main Points

The forming and empowerment of a change team in charge of the reform was one of the government's strategies to pursue health reform in Colombia. This change team was able to achieve results because of the particular strategies it used, but also because its work was part of a larger state reform agenda. Another determinant factor was the team's close relation to the economic change team. The team's legitimacy came from its academic training and its track record in government. It was a small group of policy-makers, most of them technical, highly trained and with some international experience. They saw themselves as apolitical. With few exceptions, none had in mind pursuing a career within government, but rather were attracted by the possibility of inducing tangible policy change. The team's joint expertise was not only in health or economics, but also in communications, law and public administration. It worked in isolation

from other groups within and outside the sector, and it was not part of the formal structure of the MOH.

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

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

This fact gave change team members independence from interest groups, but also vulnerability, since its permanence in power and its capacity to act depended exclusively on the support of its vertical networks. In addition to those vertical and horizontal networks, the team worked in establishing state-society networks with particular groups that could support its reform agenda politically, but also by providing valuable information and knowledge.

The team's composition, networks and strategies changed according to the stage the reform was at. During the stage of formulation and legislation, it had contact with many different groups involved in the reform. However, during the development of regulation it insulated itself from interest-group influence. This isolation was partly the result of time constraints, but also it was a deliberate strategy aimed at retaining control over the reform's content. While this strategy

allowed the team to develop an important number of decrees and prepare the reform's implementation – by establishing the basis for the development of the new providers under the new system – in a very short period of time, it became an important source of conflict during the transition period to a new administration.

The team tried to institutionalise policy change through different strategies: the legal one, which was very important and was materialised in the approval of Law 100 and its regulatory package; changing key personnel, but also the structure of the MOH, and establishing networks with co-operative personnel already working at the Ministry; trying to convince the group that was going to replace them in power of the benefits of the reform and placing some of the team's members within the new group. These strategies were complemented by securing the approval of significant loans from the World Bank and the IDB to support the transition to the new health system; and with the establishment of an international network of leading international experts who favoured the reform. The sustainability and long-term benefits of these strategies will have to be assessed in the light of the reform's implementation, which is still in process.

The health change team took two crucial decisions during the reform that have had mixed results during the implementation process. First, it decided to formulate a law with general principles that could then be further developed more precisely once the reform was back in control of the Executive, during the formulation of the body of regulations. This strategy facilitated the Law's approval and, at the same time, gave enormous room for manoeuvre to the health change team during the issuing of decrees. Nevertheless, this very same space propitiated by the broad terms of the Law was used against its underlying principles once the new administration took power and the change team was no longer in control.

Secondly, it decided to give priority to the development of the new providers that were to operate under the new system, instead of concentrating on the direct transformation of the old existing ones – which presented great political obstacles. In doing so, the change team thought that the new providers – as well as the new

allocation of resources – would stimulate the transformation of the old ones. However, these expected results have taken longer to materialise, and, at present, the health system is made up of an array of new providers operating under the reform's rules, alongside old providers who are still operating under the rules in place prior to the reform.

## Footnotes for Chapter 4

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<sup>1</sup> Where he concentrated on income distribution in Colombia under the supervision of Jeffrey Sachs.

<sup>2</sup> He became Minister of Health in November 1992. After leaving government with the arrival of the new administration, he went to work for three years in multilateral organisations as senior health expert (World Bank, IDB). Upon his return to Colombia in 1997 he assumed the direction of a business and economics publication -“Dinero” – and continues to play an important role in public debates particularly related to economic and development topics.

<sup>3</sup> See for instance Londoño, 1996.

<sup>4</sup> Interestingly, Paredes was not immediately brought into the core of the team due to her lack of academic credentials from foreign universities. She won her place as second in importance due to the team’s - and Londoño’s - dependence on her hands-on knowledge of the field and institutional memory.

<sup>5</sup> Currently she is working for ACEMI, the pre-paid medical organisations’ association.

<sup>6</sup> After August 1994 she went back to Washington and joined the World Bank.

<sup>7</sup> Through Londoño’s influence, he later became Director of the Health Superintendence from 1993 to 1994.

<sup>8</sup> He developed, along with Ivan Jaramillo, Law 60/1993, with which the allocation of fresh resources to the new health care system was secured.

<sup>9</sup> During her tenure as Bogota’s Health Secretary significant progress was made in the process of decentralisation and greater hospital autonomy. A more efficient division of responsibilities with other government agencies was established, freeing up resources in public hospitals. As a result, public hospitals increased their revenue 8.8 times the amount assigned by budgetary allocation. Hospital boards were organised with the participation of consumers, and a system of civil service (or administrative career) was also put into practice. However, the formal conversion of these public hospitals into state Social Enterprises was blocked in the local Congress at the request of unions. A successful primary health care program was implemented – and later on replicated in other regions in the country by the MOH – and a visible and very fast incorporation of the poorest sectors into social security was pursued. Also during her tenure, the territorial council for the health component of social security was created along with 19 ESS.

<sup>10</sup> Following this stand, he had concentrated his academic and research activities, as well as policy formulation in government in areas such as education, income distribution and health. For this reason he was perceived by his peers more like a man of the centre, instead of an orthodox neo-liberal (Interview, 11/03/98).

<sup>11</sup> Between August 1 and August 5, 1994, his last week in office, President Gaviria approved 22 decrees related to the health reform’s implementation.

<sup>12</sup> For instance, the Labour Ministry – leading the pensions reform – actively participated in obtaining Congress’ agreement in principle to vote for the pensions and health reforms prior to Gaviria’s direct involvement in this effort. Also, the fact that the pensions team was directly involved in lobbying legislators on behalf of the joint initiative, spared the health team the need to bargain with the most reticent factions in Congress.

<sup>13</sup> The rationale behind the formation of this group is a clear precedent of the formation of the health change team as a strategy to streamline policy formulation. But the *Mision Social* was not a change team since its responsibilities were strictly technical and not related to policy-making or political manoeuvring.

<sup>14</sup> This strategy was also feasible given the leeway incoming ministers had to remove and appoint mid and high- level non-unionised personnel due to the lack of a civil service.

<sup>15</sup> With this aim in mind, Londoño also tried to give a sense of mission to the MOH bureaucracy and effectively managed to “upgrade” it from the “second-rate status” it had when he arrived – compared with other government agencies (Interview, 07/10/98).

<sup>16</sup> While it may not be classified as a state-society network, during this period another group played a key role in supporting the change team’s reform formulation. It was formed by an extended group of international experts who were systematically consulted by the change team (Interview, 05/11/98). Such was the case of Philip Musgrove, who had participated in the production of the World Bank Report (1993), which focused on health reform ; William Hsiao,

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who was heading what was called the Harvard Colombia project from the Harvard School of Public Health; José Luis Bobadilla, who had participated in the production of the World Development Report (1993); Julia Walsh, who was at the Harvard School of Public Health ; Robert Evans, who was a leading health economist and an expert in the Canadian health care system, and had participated in the international debate on health policy formulation in different organisations; and Julio Frenk, who had been working in collaboration with the Harvard and the World Bank teams on different topics, and was heading the formulation of a health reform proposal for the Mexican health care system (Interview, 11/03/98).

<sup>17</sup>The formal presentation of a bill to Congress has to be done by a legislator even when it stems from the Executive.

<sup>18</sup>He was in charge of Law 60, 1993, which was crucial in many respects for the health reform. Particularly as concerned the health system's decentralisation and the fresh resource allocation into the health system.

<sup>19</sup>Such was the case of already existing semi-private organisations which managed health insurance plans, such as the *Cajas de Compensación Familiar*, or the pre-paid medicine companies. All of them had experience and information that was key to enable the change team to finalise the reform's regulation package (Interview, 11/12/98).

<sup>20</sup> The health change team reinforced this image by purposely relying heavily on data and diagrams to present its arguments to legislators (Interview, 05/19/99).

<sup>21</sup> For example, in some instances, the selection of regions where the first ESS were going to be created and put into practice in order to expand access to health services, included this political criterion.

<sup>22</sup> Of all the societal actors involved at this stage, the change team only considered one think tank (Fedesarrollo) as an equal with which to engage in policy dialogue on technical terms (Interview, 05/11/98)

<sup>23</sup>For instance, WB Loan No. P006854/1993

<sup>24</sup> Such was the case of a Harvard-based consulting group to prepare the master implementation plan, monitor the reform's implementation process and eventually evaluate its impact (Interview, 05/19/98).

<sup>25</sup> These meetings were preceded by a series of meetings the change team had organised during the presidential campaign in which members of the contending presidential candidates' teams were invited, along with international health experts, in order to promote the health reform and explain it.

<sup>26</sup> As part of the effort to ensure the reform's continuity, and persuaded that he would be appointed as the new Health Minister, the change team made special efforts to lobby Augusto Galan, a member of the Samper presidential campaign, about the need to continue with the health reform. He was not appointed and instead Alonso Gomez, one of the policy-makers who had been alienated, was – and he was largely responsible for the derailing of the reform's initial implementation. However, when Gomez resigned, Galan was appointed Health Minister, and it was thanks to his efforts that the reform was to be put back on track.

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**PART III**

**Mexico Case Study**

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## Mexico – Chronology of Events

Year(s)	Milestones
1935	Institutionalization of a strong presidential regime.
1938	Foundation of the PRM (later PRI) and incorporation of social sectors to the official party.
1943	Merger of the Department of Public Health and the Ministry of Social Assistance to create the Ministry of Health and Assistance (SSA). Enactment of Social Security Law. Foundation of the Mexican Institute for Social Security.
1959	Reform of the Social Security Law in order to expand coverage to new occupational groups.
1961	Inauguration of the National Medical Centre, the largest concentration of third level hospitals in the country. Its control is transferred from SSA to IMSS.
1965	Medical profession movement starts and is repressed.
1979	Implementation of IMSS-COPLAMAR in an effort to expand the coverage of basic health services to rural areas.
1982 – 1988	<b>De la Madrid Administration</b> Debt crisis.
1983	Integration of the Health Cabinet presided by the president to coordinate health policy.
1984	The right to health protection is legislated in the Constitution.
1985	Earthquake in Mexico City. Considerable damage to tertiary care facilities. Deepening of the economic structural adjustment strategy. Beginning of the pro-democracy civil movement.
1986	Decentralisation of health services is completed in 15 states. Establishment of the National Health Council
1987	Creation of the National Institute for Public Health (INSP). Decentralisation of health services is completed in two more states, and then brought to a sudden halt.
1988 – 1994	<b>Salinas Administration</b>
Mid 1993	Genaro Borrego is designated IMSS Director. Creation of CEDESS.
	Change in the leadership of the economic team's pensions reform project.



<b>Dec 1993</b>	Gabriel Martínez joins IMSS' Finance and Systems Division.
<b>1994 – 2000</b>	<b>Zedillo Administration</b>
<b>Dec 1994</b>	Economic crisis. Minister of Finance Serra Puche resigns.
<b>Jan 1995</b>	LXXVI General IMSS Assembly: Beginning of formal social security reform process.
<b>Early 1995</b>	Publication of the Health Sector Reform Program (1995-2000).
<b>Mid 1995</b>	Presentation of IMSS document <i>Hacia el Fortalecimiento y Modernización de la Seguridad Social</i> .
<b>Mid 1995</b>	Approval in Congress of a 50% increase to the Value Added Tax.
<b>Oct 1995</b>	Labour, business and government join an IMSS' sponsored Consulting Forum <i>Comision Tripartita para el Fortalecimiento del Instituto Mexicano del Seguro Social</i> to discuss IMSS reform.
<b>Nov 1995</b>	Presentation to President Zedillo of the document <i>Propuesta Obrero Patronal de Alianza para el Fortalecimiento de la Seguridad Social</i> resulting from the forum.
<b>Nov 1995</b>	President Zedillo presents before Congress the initiative for the New Social Security Law.
<b>Dec 7, 1995</b>	The New Social Security Law is approved by the Lower House of Congress.
<b>Dec 12, 1995</b>	The New Social Security Law is ratified in the Senate House of Congress.
<b>1996</b>	Conformation of an inter-agency group to develop IMSS quota reimbursement and the regulation of the emerging HMO market ( <i>ISES</i> ).
<b>Mid 1997</b>	In mid term elections, the government's PRI party loses its majority in the Lower House of Congress.
<b>Jul 1997</b>	Enactment of the New Social Security Law.
<b>Apr 1999</b>	The Insurance Law amendment creating and regulating <i>ISES</i> is approved in the Lower House of Congress.
<b>Dec 1999</b>	The Insurance Law amendment creating and regulating <i>ISES</i> is ratified in the Senate House of Congress.

## **Chapter 5. Political Context**

### **5.1 Introduction**

During the Zedillo administration (1994 - 2000), a health reform initiative was formulated and presented as part of the government program. Although the reform initiative considered the health sector as a whole, policy change was planned in the form of two separate but parallel processes: One, undertaken by the Ministry of Health (SSA), concentrating on the decentralisation of its health-care services; and the other, implemented by the Mexican Social Security Institute (IMSS), concentrating on its financial reorganisation and the introduction of a public/private mix in health service provision.

President Zedillo's economic team perceived the IMSS reform as an element of their economic reform, but also as a reform initiative bridging economic and social-sector reforms. The reform of the IMSS' health services is relevant because they officially catered for 57% of the total population. But also because the IMSS' health service provision operated along the lines that reflected the country's political context that prevailed until the early 1980's. This reform initiative brings to light most of the aspects of the politics of health reform – and indeed social sector reforms – in Mexico, since behind this initiative converge the changing political context, the politics involved in the health reform process proper, and the strategies used by reformers to bring about change.

This chapter analyses the political context in which the initiatives to reform the IMSS' health component were formulated and attempted. It first presents the characteristics of the Mexican political system, such as the formal and informal rules that structure the division of powers between the Executive, Legislative and Judicial branches of government, and the corporatist arrangement in state-society relations. A profile of the relevant actors involved in public decision-making is presented with particular emphasis on the societal actors most relevant to the specific arena of health reform. The chapter then presents the emergence and

consolidation in power of the technocratic group of policy makers who were to lead the health reform initiative.

## **5.2 The Mexican Political System**

### **5.2.1 Division of Powers and Policy-Making**

Mexico is a Republic formally constituted as a federal state and structured according to the principle of division of powers<sup>1</sup>. The concentration of formal and informal powers in the Executive, however, has led to an over-centralisation of power and an uneven balance among the branches of power, in such a way that the Executive controlled the Legislative and the Judiciary until the late 1990's<sup>2</sup>. The 1917 Constitution<sup>3</sup> determines that the Executive power should be concentrated in the president and endows him with ample prerogatives. It contains limited checks and balances that the Legislative and the Judicial branches can use to control the Executive, and even fewer are put into practice (Weldon, 1997).

### **5.2.2 The Executive**

The president, who is elected every six years with no right to re-election, has the formal prerogative to name the heads of the 16 ministries<sup>4</sup> and their vice-ministers. The core ministries, those with outstanding weight in policy decision-making, form the economic cabinet: the Finance Ministry (SHCP), the Commerce Ministry (SECOFI), the Labour Ministry (Secretaría del Trabajo), the Social Development Ministry (SEDESOL), and the Office of the Presidency (Oficina de la Presidencia). The Central Bank (Banco de Mexico) also plays a major role in macroeconomic policy and the design of programs with a high financial content such as the pensions reform.

Policy decision-making occurs in the Executive cabinets, which are chaired by the president himself. These cabinets are organised by policy areas and are the economic cabinet, the national security cabinet, the social policy cabinet, the foreign affairs cabinet, and the agriculture cabinet. When a policy issue acquires

special relevance, the minister responsible for that sector is summoned to present the issue in the economic cabinet. Such was the case of the pensions and health reforms – as well as the poverty alleviation program – which were normally assigned to the social policy cabinet.

The Office of the Presidency was created in an effort to rationalise and supervise policy decision-making and bring it even closer to the president's control by means of a small group of advisors responding exclusively to him. Although its creation was at first an informal institutional arrangement, it grew in size and acquired central importance in the 1980's, and its power and influence peaked during the consolidation in power of the technocracy in the early 1990's. It was made up of a series of technical groups each corresponding to a policy area specific to each cabinet. The Office of the Presidency was formally restructured into two presidential advisory groups in 1997.

The Finance Ministry is the other government agency with a similar level of influence in policy decision-making. Its power was further increased as a result of the merging of the Planning and Finance ministries in the late 1980's. It is from the rank and file of these core government agencies that the technocratic group emerged and seized power in the early 1980's.

### **5.2.3 The Legislature**

Legislative power in Mexico is exercised by Congress, which is composed of the Lower House and the Senate. Both bodies need to approve a law for it to be legislated<sup>5</sup>. When a bill is received by one of the legislative chambers, one or several commissions are appointed to study it. Once the commissions have discussed the bill, their recommendation is forwarded to the general assembly for its final discussion and vote. If approved, the bill is then remitted to the other congressional chamber where it follows a similar procedure. At the end of the process, the bill is sanctioned by both chambers and sent to the Executive, who has the obligation to issue it and order its compliance<sup>6</sup>.

Throughout Mexico's modern political history starting in the 1930's, Congress has played a weak role in the institutional balance of powers. By law, the Executive can submit bills to Congress and can veto Congress' resolutions<sup>7</sup>. These formal attributions along with the president's *extra-constitutional* powers derived from his relation to the ruling party<sup>8</sup>, converted the Executive into virtually the sole source of bills in the public agenda (Weldon, 1997). Until the PRI lost its absolute majority in the Lower House in 1997, Congress rubber-stamped the Executive's bills without presenting effective opposition. But Congress' new party composition has forced the Executive to lobby its bills for the first time with opposition parties - as well as with its own party membership<sup>9</sup>. This has represented a slow movement towards equal balance of powers between both branches.

#### **5.2.4 The Judiciary**

The Judicial branch is made up of the Supreme Court, the tribunals, the district courts of justice and the Federal Judicial Council. It has been the weakest of the three powers and has faced serious institutional problems in the administration of justice due to the lag in the modernisation of its procedural capacity.

The Zedillo administration presented to Congress a reform initiative to restore the Judiciary's independence from the other two branches of power and to make its procedural capacity more efficient<sup>10</sup>. This institutional reform allowed the Judiciary to de-politicise its role and acquire a certain degree of autonomy. Efforts included the creation of the Federal Judicial Council, the reconfiguration of the Supreme Court, and the modification of the prerequisites for the nomination of judges and the President of the Supreme Court – none of whom can now be appointed or removed by the Executive alone. However, the strengthening of the Judiciary's institutional capacity has proven complex and slow to have a significant impact in the balance of powers (Aguinaco Alemán, 1997).

### **5.2.5 Structuring Politics: The Corporatist System of Interest Representation (1929 – 1982)**

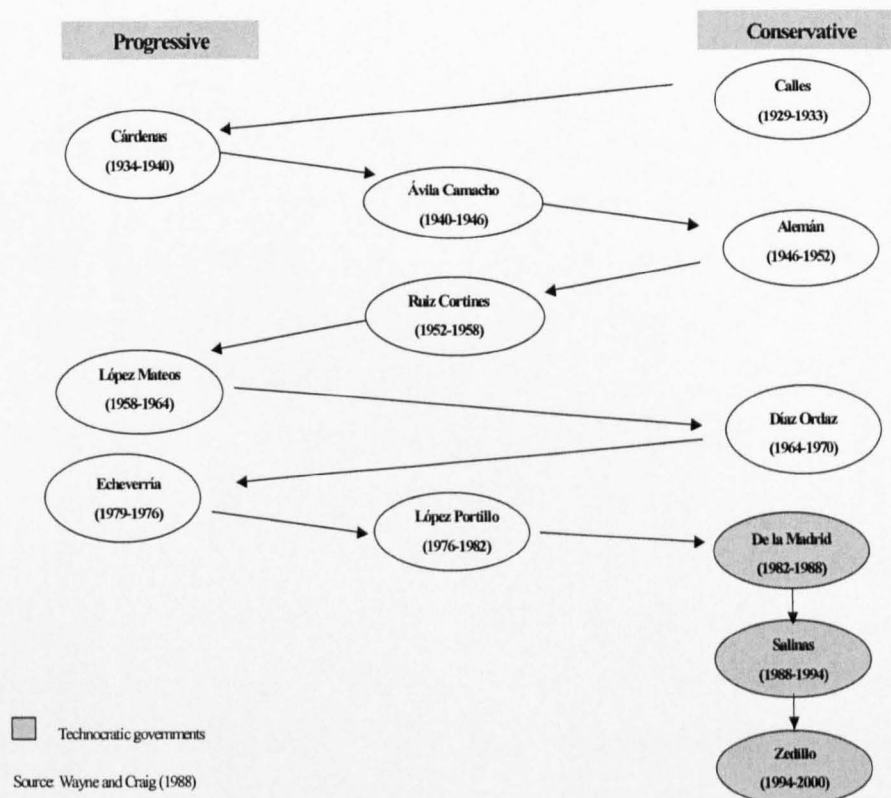
The political system that emerged in the late 1920's, and that lasted until the early 1980's was organised around a corporatist model<sup>11,12</sup>. State-society relations were structured around the *Partido Revolucionario Institucional* (PRI), the official party, in which organised groups – originally created or supported by the state – representing key interests in the state, the economy, and society, were incorporated (Stevens, 1977). Through this political arrangement, the state secured the political support of these groups, and in exchange, gave them privileged access to public goods and services.

The stability of the Mexican political system was thus built around a coalition formed by state-society alliances that were constantly renewed through the political use of public policy. As a result, the logic behind policy decision-making was permeated by the need to maintain the equilibrium of this coalition of support. Policy-makers resorted to a combination of concessions and impositions when considering who got what, how and when in the distribution of public goods and services (Purcell and Kaufman, 1980). The state bureaucracy in charge of managing and providing these public goods and services became a vested interest in its own right and a central political player as intermediary in these state-society relations.

This was the case of social security and its health-care services. Organised groups - predominantly official unions representing state workers and formal economy employees – were granted exclusive access to pensions and health services through a social security system that excluded all those who did not have formal employment, or who were not politically organised. And state workers in charge of managing and providing such services – including health manpower – became key political intermediaries<sup>13</sup> (Hernandez Llamas, 1982).

The inclusion of organised societal groups in the corporatist arrangement also converted the PRI into a state mechanism of mass control, and the central arena for political negotiation. Since the official party acted as an extension of the Executive, interest group representation and participation in policy decision-making happened within the party and the Executive. This made political participation gravitate away from democratic political party competition, and from Congress – which was reduced to rubber-stamping the Executive’s bills (Bizberg, 1989). The groups that were incorporated within the limited and very structured instances of the official party and the Executive did not share the same ideology, and competed to have their respective ideological stand and policy agendas prevail. This explains why in spite of the fact that the PRI remained in power for 71 consecutive years, Mexico’s policy agenda followed a “pendulum pattern” swaying between liberal and conservative ideology, similar to that in democracies with party alternation (Cornelius and Craig, 1980). Figure 5.1 borrows the diagram from Cornelius and Craig (1980) depicting this idea.

Figure 5.1: Ideological Shifts of PRI Governments



The structuring of state-society relations around the single-party corporatist arrangement also implied that all those groups who did not have formal employment or who did not belong to a state-sponsored organisation, faced significant barriers in accessing political participation, and were excluded from policy decision-making. Furthermore, societal groups that were not organised and therefore were not relevant in the maintenance of political support, did not share equal access to public goods and services, in spite of having equal needs (Ward, 1994). Therefore, while in official discourse social benefits were distributed according to the state's commitment to improving the living conditions of the population, access to them reflected each group's bargaining capacity in state-society relations.



This mechanism of selective political incorporation went hand-in-hand with the development model that prevailed until the late 1970's, which assigned the state a central role in allocating public goods and services. Until that time, public resources were sufficient to sustain this strategy, but the economic crisis of the early 1980's curtailed the state's capacity to maintain political stability through these means (Meyer, 1992). Added to the lack of public resources, the diminished role assigned to state by the technocracy in the 1980's not only precluded the incorporation of new groups under the rules of the old corporatist arrangement, but rendered it incapable of maintaining its traditional base. Thus, lacking public funds and debased of its pro-state ideology, the corporatist structure of state-society relations started to be dismantled from within the state.

The country's economic, social and political profiles had also changed rapidly. From the 1970's onwards, the population's growth and rapid urbanisation surpassed the rate at which formal employment was created in the cities, forcing urban groups to join the informal economy. These groups grew in size as a result of the drop in formal employment caused by the economic crisis of the 1980's. While excluded from the corporatist pact – since they did not hold formal employment, nor did they belong to PRI organisations – these groups acquired relevance in the political context. More educated and urbanised, they soon joined social movements that started to outnumber the corporatist organisations, and pressed to have a share in the distribution of goods and services, as well as participation in policy decision-making (Woldenberg, 1992).

Thus in the 1980's, as a result of the economic crises and the neo-liberal economic reform, the state was forced to redefine the rules for state-society relations. And in doing so, the administrations that pursued structural adjustment in the 1980's and 1990's faced a dilemma. On the one hand, the imposition of painful economic measures needed a strong state apparatus like the ailing corporatist arrangement. On the other hand, the downsizing of the state – which was a central part of the structural adjustment agenda – would dismantle it. Furthermore, policy-makers needed to reach out for new societal groups by improving their access to public

goods and services in order to form a new political coalition that would work against the corporatist groups' resistance to change (Cavarozzi, 1994).

In the light of this new political context, policy-makers perceived state bureaucracies in charge of social service provision – including health services – more as an obstacle than an asset. They were perceived as self-serving interest groups that were hampering the renovation of state-society relations by diverting the bulk of public resources into wages, providing inefficient services, and maintaining the old corporatist *criteria* (Ward, 1994). A new social policy agenda was designed that by-passed this bureaucracy in an effort to target new disenfranchised societal groups and the poor, and thus form a new political coalition strong enough to challenge the corporatist arrangement.

But the societal groups that were given access to public goods and services through these new *criteria* lacked a level of political organisation comparable to that of the resilient corporatist groups. Furthermore, state-society relations could not coalesce around them since the benefits of economic reform were not made tangible to them in a systematic manner (Cornelius, 1994). The technocracy thus reshaped its reform agenda. It confronted the corporatist arrangement in those areas that were directly related to the economic reform, but refrained from doing so in areas that were not, and that still played a significant role in maintaining political support. Such was the case of the unionised state bureaucracies in charge of providing social security services.

### **5.3 The Actors**

#### **5.3.1 Political Parties**

In spite of the PRI's seventy-year-old predominance as the official party, opposition parties from both sides of the ideological spectrum were part of the political context. However, with few exceptions, only since the late 1980's were elections fair enough to allow these parties to reach power at local and state level.

The slow process of political liberalisation led to the end of the PRI absolute majority in Congress in 1997, marking a turning point in the interaction between the Executive and Legislative branches. The Executive's lack of direct control over Congress through the official party, empowered legislators – from both opposition parties and the PRI – to function as a check and balance, demanding a say in policy decision-making. In late 2000, for the first time in Mexico's modern history, an opposition party will reach the presidency.

Of the more than eight officially registered opposition parties, two have coalesced in major political forces opposing the PRI. To the left, the Partido de la Revolución Democrática (PRD) was created in the late 1980's from the union of an internal division of the PRI – resulting from the technocracy's take-over of the party – and an array of left-wing political organisations. By the late 1990's, the PRD had carved a niche in the centre left that was abandoned by the PRI due to the neo-liberal program it adopted from the 1980's onwards. After being close to winning the 1988 presidential elections, by the late 1990's it held Mexico City's mayoralty and some state governorships, as well as several municipalities. It has played a major role in pressing for the country's democratisation and in Congress has systematically voted against the Executive's pro-market liberalisation policy initiatives. Along those lines, it has openly joined forces with the groups resisting IMSS reform.

To the right, the Partido Acción Nacional (PAN) was created in the late 1930's by bringing together a myriad liberal civic associations which resented the rapidly expanding state interventionism. During the following decades, with few exceptions, it had no clear chances of winning electoral posts given the state's control over elections, but maintained its role as minority opposition in Congress. It nonetheless continued to press for political liberalisation until, from the mid-1980's onwards, it was able to govern three states, the two most important cities after Mexico City, and several others, along with local governments across the country. With few exceptions – related to political bargaining – the PAN has steadily sided by the Executive's neo-liberal agenda from the 1980's onwards. In

July 2000, it won the presidential elections, ending the PRI's seventy-one-year hold on power.

### 5.3.2 Business

Although not formally part of the PRI's corporatist arrangement, business represented a base of tacit political support for the state from the 1950's until the 1980's<sup>14</sup>. In exchange for this support, and as part of its economic policy, the state granted businesses protected markets, subsidies and other benefits. Due to its key role in productive processes and its control over financial resources, the business elite had personal access to high-level public officials through informal channels, without the need for institutional forums (Luna et al., 1987). However, the formal intermediaries between the government and business were the chambers of commerce<sup>15</sup>.

The arrival of technocracy to power and its market liberalisation agenda in the 1980's changed the composition of the business-state network. While a part the business sector that was negatively affected by the market liberalisation policies and voiced its opposition to these measures, business groups that benefited from it, established more visible alliances with the technocratic group in power. This resulted in a well established state-society network in which big business gave its open political backing to state policies and shared information and knowledge with policy-makers who showed interest in pursuing reforms.

For the first time, the business community had public-policy proposals prepared in private think tanks and presented them to the Executive. In most cases, these policy proposals were directed at the economic sphere. However, in the early 1990's, a group of businessmen financed the *Health and Economy* project undertaken at the Mexican Health Foundation (Funsalud), a private-sector-funded think tank. Their idea was to have a serious technical argument that could justify an in-depth reform – or dismantling – of the Mexican Institute of Social Security (IMSS), which, in their view, was an inefficient state agency. Although the

resulting document fell short of proposing the dismantling of IMSS, it presented a comprehensive long-term proposal for the transformation of the entire sector, including the in-depth reform of IMSS. The proposal was lobbied by important members of the business community with the economic team in power, and succeeded in influencing the Zedillo administration's health sector reform program.

### **5.3.3 Labour**

Since their incorporation into the PRI in the late 1930's as a central element of state-society relations, official unions have successfully maintained their role as exclusive intermediaries between the state and labour and between policy-makers and state employees. They have obtained exclusive benefits for its membership and monopolised control of key state industries as well as state agencies in charge of the provision of social services – such as IMSS. Although unionised labour represented less than 25% of the economically active population, its political and economic influence was considerable. The oil workers' union, the state electricity enterprises unions, the teachers' union and social security unions were among the largest and strongest in the country.

The structure of representation and participation of these official unions was vertical and authoritarian along the lines of the corporatist arrangement. During the structural adjustment process in the 1980's and 1990's, the state resorted to the leadership of these official unions to ensure its implementation, while at the same time preserving political and economic stability (Cavarozzi, 1994). However, these structural adjustment measures made them lose ground in the political arena, since they were unable to protect the interests of their membership. Furthermore, societal groups with informal employment and independent unions became more vocal and challenged the official unions' monopoly of interest representation and interaction with the state.

This rivalry between official and independent labour movements, and each union's calculations about their political allegiance, was a major factor in the politics of the IMSS' health reform. On the one hand, the political strength of the IMSS' union, coupled with its veiled threat to change sides and join the independent movement, was a matter of concern for the government, which could not afford to be at odds with more corporatist organisations than those related to the economic sphere. This helped the union to make an effective resistance to change. On the other, the union's half-hearted willingness to abide by the old corporatist rules put it at odds with the rest of the still powerful official unions, and thus impeded it from finding allies and forming a large labour coalition to resist the change<sup>16</sup>.

### 5.3.4 Bureaucracy

The state bureaucracy in Mexico was divided into three levels: high, middle and low level. High-level bureaucrats or policy-makers did not promote their interests through unions or any other type of formal organisation, but instead pursued their careers and protected their interests through informal links with other policy-makers, by means of vertical and horizontal support networks. As high-level bureaucrats did, mid-level officials sought to promote their interests through bureaucratic factions or *camarillas*. Only low-level public employees joined state workers' unions in order to pursue and protect their interests by means of collective action (Cornelius and Craig, 1988).

The Mexican Social Security Institute (IMSS) was an exception among government agencies in that most of its employees, including high and mid-level officials, were members of the Institute's workers' union. Practically all of the Institute's employees, including doctors<sup>17</sup>, were members of the SNTSS, which represents all IMSS employees. The union's control over most positions, including high-level posts, increased its pressure and collective action resources and reduced the margin of manoeuvre of the IMSS' Director and his close team.

Given the lack of an institutionalised civil service in Mexico, the change of administrations brought with it a massive renovation of personnel within the public sector – and, in fewer cases, between the public and the private sector. The higher the rank of the bureaucratic level, the higher the degree of circulation. Due to the lack of institutional mechanisms for a meritocratic career, policy-makers were dependent on closely tied groups, or *camarillas*, and the networks they built up while in a government position to ensure the continuity of their careers (Camp. 1990). The president appointed all cabinet ministers and vice-ministers, but ministers had a say in the nomination of some of their close collaborators. Each of these, would in turn name his/her work team, and loyalty and trust were prioritised over expertise and performance (Grindle, 1977).

The various *camarillas* constantly competed to increase their influence on the decision-making process, as well as on the formulation and implementation of public policy. This bureaucratic competition determined, more than anything else, who held the high-level positions in government (Camp, 1990), and therefore which policy project was implemented. Bureaucratic faction competition also reflected competing ideologies and visions, and has resulted in significant changes in the direction of policy-making. The power to influence policy decision-making depended on the group's characteristics and its networks with other policy-makers. Given that, until the late 1990's, the president had the power to designate his successor, the number and importance of the policy projects each *camarilla* was in control of, often signalled its closeness to the top of the bureaucratic pyramid – and thus its positioning in preparation for the following administration. This explained in part why, as the change of administrations approached, competition peaked and cohesion around the government's policy agenda faltered.

The arrival of the technocracy to power in the early 1980's was the result of one of these power struggles. As had been the case in the past, due to the lack of democratic party competition, this bureaucratic rivalry reflected the state's change in ideological stand in response to society's perception of its performance, and national and international pressures to alter its policy agenda. The technocratic group that reached power saw itself as the purveyor of an "apolitical" approach to policy-making, exclusively based on technical expertise and professional track record. However, the group resorted to similar bureaucratic strategies as other *camarillas* to pursue power and maintain it.

### **5.3.5 Civil Society**

Since the mid 1960's social movements started to organise themselves in demand of political liberalisation and participation in policy decision-making<sup>18</sup>. Since then, civil society has followed a long process to regain spaces outside the corporatist state-society relations. During the 1960's and 1970's, those groups that contested



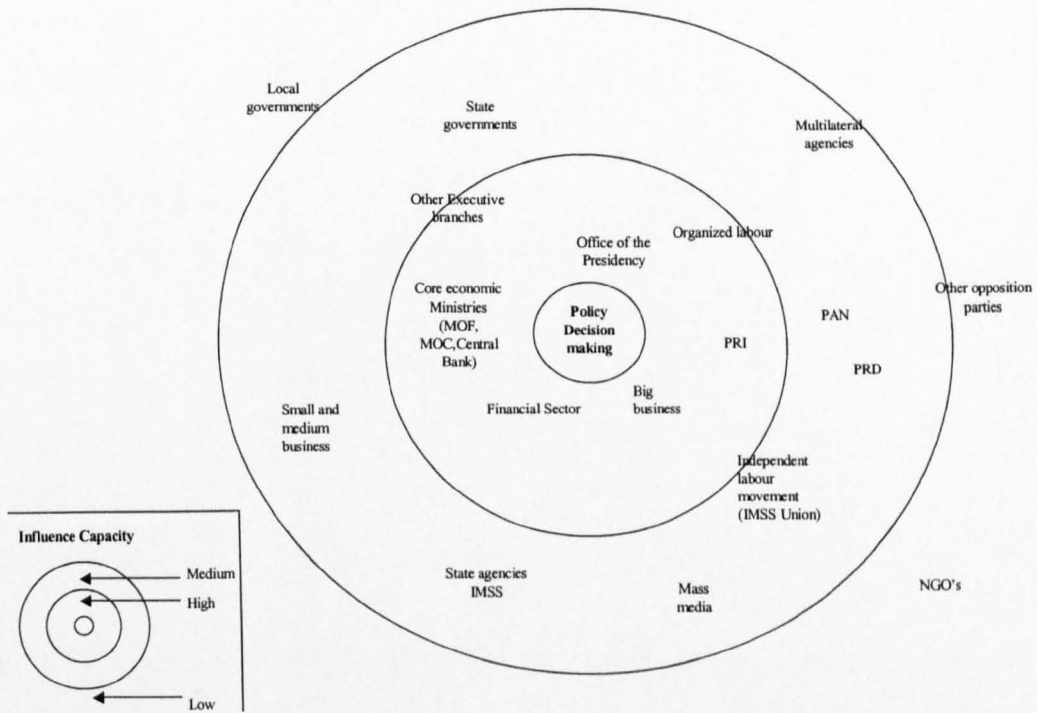
the state's authority – particularly left-wing movements - were repressed and/or co-opted by it. Self-help groups and peasant organisations that were not controlled by local PRI politicians (*caciques*), were repressed or denied public services and resources in a “carrot-and-stick” strategy. However, as a result of the continuous economic crisis and the state's exhausted capacity to absorb new groups, the latter started to press the state on several fronts in search for more access to policy decision-making and public goods and services.

The emblematic birth of the civil society movement was the 1985 earthquake in Mexico City. Faced with the state's slow reaction in helping earthquake victims, societal groups and citizens organised themselves in self-help groups. Since then, civil society has played a visible role demanding free elections, a stop to mass-media control, and respect for human rights, among other issues. The Zapatista guerrilla movement that emerged in the state of Chiapas in 1994, also brought the state's and society's attention – in Mexico and abroad – to the problems of poverty and income concentration that the state had been unable to solve.

A handful of grass-roots non-governmental organisations, social assistance associations, and private-sector-funded think tanks of different ideological affiliations, started to play a more visible, if still marginal role. Among the think tanks sponsored by the private sector, two stood out for their capacity to influence policy-making through direct contacts with government decision-makers in the 1980's and 1990's. The *Centro de Investigacion para el Desarrollo, A.C.* (CIDAC), and the *Fundacion Mexicana para la Salud* (Funsalud).

Figure (5.2) shows the political map of key actors with capacity to influence policy decision-making during the 1980's and 1990's. Policy decision making is presented in the middle of the concentric circles. The closer the actors are to this inner circle, the higher their power to influence policy decision-making.

**Figure 5.2: Political Map of Key Actors**



## **5.4 Technocracy in Power**

Two phenomena single out the early 1980's in Mexico. The debt crisis, followed by the arrival of technocracy to power with a neo-liberal policy agenda. These events were determinant in the redefinition of state-society relations and the re-composition of the coalitions that supported the state and benefited from its economic and social policies. The magnitude of the economic crisis undermined the legitimacy of the economic model in force until the early 1980's, and severely damaged the credibility of the politicians and policy-makers in power who promoted it. Thus, the crisis opened a window of opportunity for a technocratic group of policy-makers to seize power, promote structural adjustment, and redefine the role of the state, the market, and state-society relations<sup>19</sup>.

### **5.4.1 Origins**

From the late 1950's, technical officials in charge of the Finance Ministry (SHCP) concentrated decision-making power over the public agenda through control over the budget and supervision of policy implementation in the other government agencies (Bailey, 1980). Finance's legal and institutional attributes were reinforced by informal and political factors that facilitated its leading role in policy-making and gave it leverage in the bureaucratic political competition among government factions. Among these, the capacity of its officials to deal with complex policy-making and the direct support of the president in each of the administrations in that period. Together with the Bank of Mexico (central bank), the Finance Ministry recruited the best prepared engineers and economists in the country and enjoyed the lowest personnel rotation rate among government agencies (Sirvient, 1975). These two agencies shared a liberal ideology and worked around a conservative policy agenda that focused on economic growth over income redistribution, low inflation rates, and keeping government expenditure low (Benett and Sharoe, 1984).

Following the political crisis of the late 1960's<sup>20</sup>, and the change in ideology brought about by the arrival of the Echeverría administration (1970 –1976), this group was challenged by equally trained officials who favoured a state-led economic model and income redistribution via high levels of public expenditure. The latter predominated and, with the support of the president in that, and the following administration, remained in control of the Finance Ministry throughout the 1970's. But the competition to influence policy-making did not subside. Instead, it was institutionalised by the creation of the Ministry of Planning (SPP), in 1976, which housed the liberal faction opposing the state-centred economic model pursued by Finance<sup>21</sup>.

It was also during this period that the divide between politicians and technical officials became less clear, and technical officials saw the opportunity to take on political positions. Becoming aware of this, young professionals interested in pursuing a career in the public sector stopped following the traditional training in law, and instead concentrated on economics. A generation of policy-makers thus chose to study economics and public administration in private universities with close links to American universities, where they followed on to pursue graduate studies. The professionals that followed this trend in the 1970's returned to junior positions in the Finance and Planning ministries and the Central Bank. They formed a cohesive group of technical officials who were willing to pursue their careers in positions that had previously only been held by non-technical politicians (Grindle, 1996).

The perceived need to renew top-level decision-makers in order to face the new challenges of the 1980's opened a window of opportunity for their arrival to power. They became a new breed of politicians, whose careers had been made in the technical ranks of the financial sectors of government, and not within the party, and who came to be referred to as technocrats. President De la Madrid empowered this group of policy-makers to lead the economic adjustment program.

#### **5.4.2 The Arrival of Technocracy to Power:**

##### **The De la Madrid Administration (1982 – 1988)**

In 1982, when president De la Madrid took office, the country was immersed in a profound economic crisis. While the origins of the crisis were domestic, the world-wide economic recession significantly increased its magnitude. The pressure of its external debt on Mexico's economy grew to unprecedented levels. In response to this situation, the De la Madrid administration implemented what was called the Immediate Program for Economic Reorganisation (PIRE) and formulated a new long-term development strategy.

The general perception in the country – and abroad – was that the world economy, and the challenges of the Mexican economy had grown too complex and required specialised expertise to solve them. Furthermore, the immediate need to reschedule debt payments with international creditors enhanced the role of the technical policy-makers. While until the crisis they had played an advisory role, and politicians were in charge of direct negotiations, this situation required them to play both roles, and the liberal economists were the only ones that shared the ideology of the creditors, and therefore enjoyed certain credibility.

Thus the crisis marked the end of the pro-state faction's dominance, and the technocratic group arrived in power. They formed a cohesive group with very similar education and social background, and shared a common policy agenda and ideology. None had strong links to the PRI, nor had experience in elected positions. But many had previously worked in the public sector as junior officials, and were the sons, nephews and students of the technical officials that had served in previous administrations. Thus, aside from their technical training and qualifications, they were skilful in bureaucratic politics (Grindle, 1996) and counted on the network of the generation of technical officials that preceded them (Centeno, 1994).

They saw themselves and were perceived by other policy-makers as the junior members of the *liberal* group who had been relegated to the SPP. From there, they had witnessed the internal political battles to control public policy, the pre-eminence of the pro-state position and the resulting policy choices that had brought about the most serious economic crisis the country had seen until then. Their arrival in power was perceived – and resented – by PRI politicians as a take-over, and they were soon referred to as the technocrats from the SPP (Waterbury, 1992).

However, the perceived urgency to confront the economic crisis meant that the technocratic group found very little organised resistance. Soon traditional PRI politicians and union leaders were displaced from key decision-making positions. With the backing of the president, the new economic team pursued aggressive political manoeuvring to expand its scope of influence beyond the financial government sectors, and into areas of political control. However, they were careful to only replace senior-level officials in areas they considered strategic for the economy, in a power-sharing strategy with traditional politicians with whom they struck an alliance.

The impact of this power rearrangement within the state was clearly reflected in public policy, which from then until the late 1990's has concentrated on conservative macroeconomic management as its main priority. The further deterioration of economic conditions in 1985 – due to a new drop in oil prices – led the De la Madrid administration to deepen its structural adjustment program, accelerating the process of market liberalisation and the privatisation of public enterprises. The radicalisation of the structural adjustment policy agenda also facilitated the consolidation in power of the most orthodox faction of the technocratic group, which was led by then Planning Minister Carlos Salinas de Gortari.

In 1987, in a new global economic crisis, the world's financial markets had their price indexes drop abruptly, pulling the Mexican market with them. The value of

the peso dropped more than 40% in one day; and as a consequence, inflation increased considerably. In response to the new crisis the government put together an economic pact – called the *Economic Solidarity Pact* (PSE) – and resorted to the old corporatist structure to ensure the joint compliance of the state bureaucracy, labour and business with its tough measures. The plan was formulated by the team in the Planning Ministry, which was gradually assuming control of economic policy.

By signing the PSE, labour leaders agreed to restrain their wage increase demands, and the leaders of the business organisations pledged to support economic liberalisation and to reduce profit margins. In return, the state committed itself to restrain public expenditures by freezing state service wage increases and undertake layoffs. All these measures had the short-term purpose of curtailing inflation, but it implied a long-term structural adjustment agenda and the radical transformation of the state and the economy. The underlying assumption is that the technocratic group that had been empowered would remain in key senior positions in the long term – i.e. through more than one six-year term in office – in order to bring it to fulfilment.

By the end of 1987, President De la Madrid designated Carlos Salinas de Gortari as the PRI's presidential candidate, and therefore, as his successor. In order to ensure policy continuity during the change of administrations, he appointed several members of the latter's team in key positions in government, where, with few exceptions, they remained after the transition<sup>22</sup>. These included positions in the Finance, Commerce, Interior, and Development ministries, as well as the Central Bank (Centeno, 1994).

#### **5.4.3 The Consolidation of Technocracy in Power:**

##### **The Salinas Administration (1988 – 1994)**

After very contested elections, the 1988 – 1994 Salinas administration marked the consolidation in power of the technocracy. President Salinas' cabinet was even

more homogeneous than President De la Madrid's, and represented a closed and cohesive elite, with roots in the Ministries of Finance and Planning. This economic team had some of its members migrate to other government agencies, in order to control the key sectors it wanted to reform. Also, in a key political manoeuvre, while President Salinas appointed this compact group of technocrats to key posts in the economic agencies, he designated traditional politicians to political control agencies, such as the Ministry of the Interior. As heads of the peripheral agencies – which were not key to his government's agenda – Salinas appointed members of societal groups considered relevant to preserve his coalition of political support. That was the case of Jesús Kumate, a military doctor, who enjoyed the support of right-wing conservative groups, and was appointed Health Secretary.

The key members of Carlos Salinas' cabinet were: Finance Minister Pedro Aspe Armella (Doctor in Economics from MIT, 1978); Commerce Minister Jaime Serra Puche (Doctor in Economics from Yale University, 1979); Planning Minister Ernesto Zedillo Ponce de León<sup>23</sup> (Doctor in Economics from Yale University, 1978); NAFTA negotiator Herminio Blanco Mendoza (Doctor in Economics from the University of Chicago, 1978); and the president's chief of staff, José Córdoba (post-graduate studies at the Sorbonne and Stanford University). A third of the cabinet members had worked at the Finance Ministry, and half of the cabinet had worked at the Planning Ministry before reaching cabinet positions.

This technocratic team shared a common neo-liberal ideology and a project to rebuild Mexico's economy. They supported the integration of the country into world markets resorting to low wages and the proximity to the United States as comparative advantages to boost economic growth. The economic team's program centred on controlling inflation as a means to stop its regressive effect on income distribution. It also set out to deepen market liberalisation and the downsizing of the state through a massive privatisation program and to seek fiscal balance at the expense of maintaining the base salary's purchasing power (Centeno, 1994).



The ideological and programmatic cohesion within the group of decision-makers was determinant for the successful implementation of this policy agenda, which reshaped the Mexican state and its relation with the economy and society. The dismantling of the Planning Ministry in 1992 returned the planning functions to the Finance Ministry reflecting at the institutional level the concentration of decision-making in this group<sup>24</sup>.

During the Salinas administration almost the entirety of public firms which were not defined as strategic in the Mexican Constitution were privatised. Such was the case of airlines, steel mills, mines, a part of the petrochemical industry and the telephone company. The banks, which had been put under state control in 1982, were put back in private hands<sup>25</sup>. Some of the peripheral activities that were carried out within state agencies that were to remain public were also contracted out to the private sector. In spite of this trend, in the case of the IMSS, only cleaning and garbage collection was contracted out to private services, in an effort not to affect the IMSS' union interests (Interview, 10/18/99).

Opposition to privatisation was headed by the unions of the enterprises that were being put on sale. The left-wing opposition parties that endorsed a nationalist, state-oriented agenda, also opposed the privatisation programs. The bureaucracy in the Ministry of Energy (SEMIP), which had been in charge of controlling the majority of the public enterprises put on sale, also actively opposed privatisation. But in spite of this resistance to change, the economic team was able to pursue its agenda with the political backing of the major labour unions and business organisations streamlined through the old corporatist arrangement.

In spite of the economic team's need of this political support, it sought to selectively challenge important segments of this corporatist structure. The reforms it was implementing hampered the corporatist exchange between PRI-affiliated groups and the state; but also the technocratic team made a serious attempt to redefine state-society relations by substituting these alienated groups – such as workers' unions and the bureaucracy affected by the reforms – with new groups

that had formerly been excluded from the corporatist pact. These new societal groups were organised under the auspices of the government's new poverty alleviation and development programs in an effort to by-pass the corporatist mediation in state-society relations.

However, the economic reform's failure to produce tangible benefits for the majority of the population, and the newly formed coalition's slowness to consolidate, resulted in a political vacuum unable to counter the resistance of politically mobilised groups, such as the unions of the public enterprises being dismantled or privatised, and the owners of private enterprises who were facing bankruptcy due to the market liberalisation. In view of this scenario, and still needing to consolidate the structural adjustment plan via economic pacts with labour and business organisations, the technocrats gave up on their attempt to redefine state-society relations and instead resorted to the old corporatist apparatus and its leaders to ensure the reform's continuity and to hold on to power.

#### **5.4.4 Technocracy Delimited: The 1994 Crisis and The Zedillo Administration (1994 – 2000)**

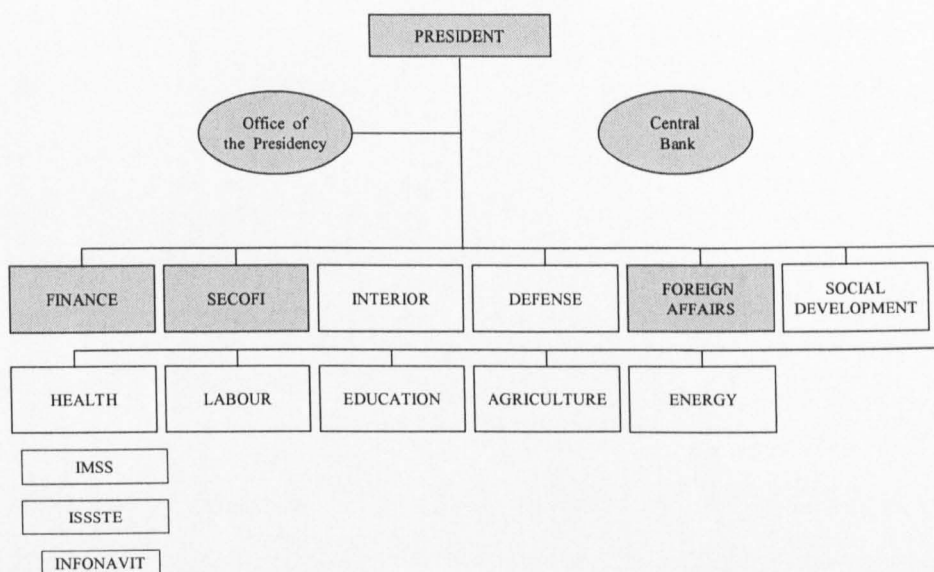
By the mid-nineties, the negative impact of the economic crises and the structural adjustment measures on the majority of the population had exerted great pressure on the political system and its stability. With very few exceptions, the majority of the population, regardless of income level, had borne the costs – albeit unevenly – without any visible positive results after years of severe economic measures. This was particularly the case with the corporatist groups at the core of state-society relations until the 1980's, which were suffering a dramatic erosion of their purchasing power and of the exclusive social benefits the state had entitled them to for decades.

The need to reconstruct state-society relations and to reconcile these groups became evident. The consolidation of the economic reforms remained the priority, but this now depended on the skills and political manoeuvring of the PRI's

politicians. President Salinas designated Development Minister Luis Donaldo Colosio as his successor, in an attempt to ensure the continuity of the economic plan, while at the same time rebuilding ties with PRI politicians. But the 1994 political crisis resulting from the assassinations of the PRI's presidential candidate Colosio and its secretary general Ruiz Massieu, thwarted President Salinas' strategy. In the aftermath, to prevent the accession to power of a PRI faction that would revert the reform, President Salinas designated as his new successor, Education Minister Ernesto Zedillo, a technical official with no political skills<sup>26</sup>.

The economic crisis that started soon after President Zedillo took office in December 1994, showed the vulnerability of the economy in spite of the structural adjustment efforts. To restore the equilibrium of public finances, the Zedillo administration was forced to increase taxes. During the first semester of 1995, after a politically wearying process, a 50 per cent increase in the Value-Added Tax (IVA) rate was approved in Congress. This initiative, along with the IMSS reform approved in December of the same year, were the only two major reforms – with an immediate impact on several societal groups – that were going to be approved during the Zedillo administration<sup>27</sup>. Legislators from opposition parties and from the PRI were concerned about having to share the responsibility – and to pay the political price – of approving unpopular measures in view of growing social discontent. Faced with very little political capital to introduce major reforms and with the need to tighten the budget once again in order to limit the damage of the economic crisis, the Zedillo administration chose to minimise its reform agenda and to concentrate on stabilising the economy. Figure (5.3) shows the location of the economic team in charge of re-defining the government's policy priorities.

**Figure 5.3: Zedillo Administration (1994–2000):  
Location of Economic Team\***



□ Location of economic team members  
\*Indicative, non comprehensive diagram

As a result of the new economic crisis and the discredit of the technocratic group in power, opposition parties grew stronger. In the 1997 mid-term elections, the ruling party lost, for the first time in Mexico's modern history, its majority in the Lower House, thus initiating a process towards the balance of power between the Executive and the Legislature. As a result of the new political context, the speed and scope of the government's reform agenda was reduced even further. During the remaining three years of government, the Zedillo administration was reactive, rather than proactive, regarding the implementation of policy initiatives, and had no political power to impose policy change on those sectors pending reform. This was the case of the petrochemical and electricity sectors, as well as of the social security reform.

While the economy recovered and major progress was made in political liberalisation, the technocratic group in power failed to convert these results into political support in the wake of the presidential elections. The PRI had modified the party's rules to avoid the fourth consecutive succession in power of a member of the technocratic group. At President Zedillo's initiative, it also moved to have more control over the designation of its presidential candidate, and former Agriculture Minister Francisco Labastida, an economist with a state service career with little ties to the technocracy, was chosen. But he lost the elections to the PAN's candidate Vicente Fox.

### **5.5 Summary and Main Points**

A distinctive characteristic of the political system in Mexico was the concentration and centralisation of power in the Executive branch of government, specifically in the president. The Executive's power is not only based on the formal attributes that the Constitution grants it. A series of informal faculties have allowed the Presidency to become the single most important source of legislation. This practice, in place for more than half a century, has transferred policy decision-making and negotiation to arenas outside the public scrutiny, such as the ruling party or the Executive itself.

However, the Presidency's informal powers have weakened as a consequence of the democratic opening. Since 1997, when the PRI lost its majority in the Lower House, for the first time, the government has had to negotiate with opposition parties the approval of its bills. Also, given the more competitive political environment, the Executive has had to step up its negotiations with its own party, since the legislators' incentives to back unpopular policy initiatives have greatly diminished.

A second relevant characteristic of the Mexican political system is the rather weakened, but still present corporatist arrangement that rules the relations between the state and different social sectors through the official political party: the

Institutional Revolutionary Party (PRI). The corporatist arrangement between the state and society rests on a set of implicit agreements that govern access to policy-making and the distribution of public goods and services. This arrangement between the state and society has rested on the exclusive inclusion of organised societal groups mostly working in the formal economy. In exchange for organised political support, the incorporated sectors receive privileged access to public goods and services from the state.

The health system in Mexico reflects, until now, the corporatist arrangement between the state and those actors it considered politically or economically relevant, to whom access to social security services were granted. It excluded those groups with little capacity for political mobilisation and whose economic activities were centred in the informal sector, notably the poor. To the latter group, the state provides underfunded and insufficient health care through the Ministry of Health facilities.

The 1980's marked the exhaustion of the political elite who had been ruling over a closed statist economy for decades, and the arrival in power of a different breed of policy makers: the neo-liberal technocrats. Their seizure of power was possible due to the legitimacy crisis that the PRI's traditional politicians were facing. Furthermore, the economic crises and the change in ideology of the group in power, seriously undermined the corporatist arrangement. The lack of financial resources limited the state's capacity to maintain the exchange of public goods and services for the organised political support of the corporatist sectors. It also prevented the state from incorporating the newly mobilised societal groups – most of whom worked in the informal economy – into the old corporatist pact.

The group of technocrats that gained strength within government in the early 1980's, under the De la Madrid's administration, was a cohesive team made up of technically skilled individuals whose political careers had developed almost entirely in the financial and economic agencies of government. Most of them

lacked electoral or party experience. The increase in the technocratic group's influence corresponded to a decrease in power of traditional PRI politicians and union leaders.

The technocratic group profited from this window of opportunity to consolidate itself in power and to pursue policy reforms that were to redefine the economic model, the role and size of the state, as well as state-market and state-society relations. However, this radical transformation in state-society relations did not happen simultaneously in all policy areas. Most significant changes occurred in the economic sphere, where market liberalisation was completed. Public enterprises were put up for sale and, in some instances, the state bureaucracy was trimmed down. Instead, the social sector's reform – which was also part of the technocracy's agenda – had a very slow start and left the old corporatist arrangements and actors almost untouched. Social sector unions, and notably the IMSS union, not only survived state reform, but were actually useful in securing the political support needed to pursue reforms in other sectors.

However, macroeconomic changes failed to translate into tangible benefits for the majority of the population, but the economic reform negatively affected interest groups that had played an important role in state-society relations for decades. The enormous pressure on the political system that resulted from these factors, undermined its *modus operandi* of the last 60 years, notwithstanding its corporatist arrangement.

Paradoxically, the technocrats who sought to limit the scope of action and even dismantle the corporatist machinery, had to turn to it in order to promote and consolidate their structural adjustment agenda. Thus, the technocracy in power was careful not to tamper with the corporatist interests in those areas that were not a priority in their policy agenda, but that played an important role in securing political support for the government and maintaining the overall political system's stability.

The liquidity crisis that occurred at the end of 1994 further complicated the prospects of the technocratic group in power. Ernesto Zedillo's government had to increase taxes to balance public finances. The political cost of promoting these reforms was so high that the government's margin of manoeuvre was considerably reduced. Nonetheless, he promoted the reform of the pensions system as a preventive measure against its imminent bankruptcy, and as a way to raise internal savings. But President Zedillo opted to reduce his reform agenda and focus on stabilising the country politically and economically. The priority given to pensions reform as part of the economic policy package, and the need to reduce potential political confrontation with organised groups such as the IMSS' union, severely limited the political feasibility of an in-depth health reform that would necessarily affect entrenched interests.

## Footnotes for Chapter 5

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<sup>1</sup>The Federation's power is divided in three branches of power: the Legislative branch, the Executive branch and the Judicial branch. Their respective faculties are to decree laws, to carry them out, and to apply them. For more details on Mexico's institutional configuration, see Berrueto, 1996.

<sup>2</sup>Córdova, 1990 and González Casanova, 1965.

<sup>3</sup>Constitución Política de los Estados Unidos Mexicanos, Editores Mexicanos Unidos, 1999.

<sup>4</sup>Ministries are: Interior, Foreign Affairs, Finance, Labour, Energy, Agriculture, Social Development, Health, Education, Environment, Comptroller's, Commerce, Agrarian Reform, Defence, Navy and Tourism.

<sup>5</sup>The sole exception is the Federal Budget, which only requires the approval of the Lower House.

<sup>6</sup>If the revising chamber does not agree with the recommendation sent by the chamber of origin, the bill is returned to the latter with amendments. If the chamber of origin does not accept the amendments, or finds that new ones need to be made, the bill goes back to the revising chamber. If this chamber does not accept the amendments for a second time, the bill is not approved.

<sup>7</sup>If the president disagrees with a law that has been approved by Congress, he can return the document with his observations to the chamber of origin for further discussion. For the law to be approved, a qualified majority of two-thirds of the votes is required. The procedure is repeated in the revising chamber. If approved, the bill is sent to the Executive, who must then issue it.

<sup>8</sup>These included being president and, simultaneously, leader of the official party which held an absolute majority in Congress. Through this informal institutional arrangements, the PRI did not operate as an independent political party for interest representation, but as the political arm of government (Gonzalez Casanova, 1990).

<sup>9</sup>Political competition has weakened the ruling party's discipline, since the costs of dissent have diminished, and those of voting in favour of unpopular bills have increased.

<sup>10</sup>For more on the 1994 reform of the Judiciary, see Aguinaco Alemán, 1997.

<sup>11</sup>A corporatist arrangement is "a system of representation of interests in which societal groups are organised in a limited number of categories: unique, obligatory, not competitive, hierarchically ordered and functionally differentiated, recognized or authorized (even created) by the state. These categories are granted a deliberate representative monopoly in exchange for accepting certain controls in the selection of their leaders and limiting their demands." (Schmitter, 1981:179).

<sup>12</sup>This political arrangement was agreed as a power sharing mechanism among power feuds to stop the 10-year long factional fighting that had followed the end of the Mexican Revolution (1910 - 1920).



<sup>13</sup> At the time of the health reform initiative in the 1990's, the public social security agencies - which included IMSS - concentrated the largest unionised state bureaucracy in the country with capacity for political mobilisation across the nation and daily direct contact with a significant portion of the population.

<sup>14</sup> The sole exception being the Echeverria administration (1970-1976), when the implicit pact between government and business was broken due to president Echeverria's attempts to further strengthen the hegemony of the bureaucracy and expand the state. The creation of the Business Coordinating Council (CCE) in 1975, marks the peak moment of this antagonism.

<sup>15</sup> Most business chambers, however, have very little representation and have served the interests of a privileged group within them.

<sup>16</sup> The refusal of other labour unions to join a coalition against the reform led by IMSS' union can also be traced back to workers' dissatisfaction with IMSS services, and to the lack of understanding about what costs/benefits it would bring to them. This ran in stark contrast with the union's perception of the negative and immediate impact the reform would mean for its membership's interests.

<sup>17</sup> After the repression of the doctors' movement, in the mid-sixties, their capacity to organize as a pressure group was restricted. The only channel for collective action left for doctors, as IMSS' workers, was the SNTSS. For more on the medical profession's movement, see Pozas Horcasitas, 1993. Also, for more on the medical profession, see Cleaves, 1987.

<sup>18</sup> The most important social movements at the time were the railway union's and the medical profession's that were repressed in the early to mid-1960's, and the student movement which was severely repressed in 1968. For more on the medical profession movement, see Pozas Horcasitas, 1993.

<sup>19</sup> For details on the take over of the technocratic team, and the transition from a closed economy model to an open economy one, see Grindle, 1996.

<sup>20</sup> During the 1960's the urban middle classes were showing growing discontent with the lack of social participation in policy decision-making. The legitimacy crisis reached its peak with the repression of the 1968 student movement. For details see Gonzalez Casanova, 1981.

<sup>21</sup> The rivalry between these two ministries prevailed until SPP was dismantled - and its activities re-taken by the Ministry of Finance - in the late 1980's. Presidents would try to control and arbitrate the competition among the rival factions by juggling their positions between these two agencies. As a result, by the late 1970's, the pro-state group controlled Finance and the liberal group Planning.

<sup>22</sup> When Salinas de Gortari resigned as Planning Minister to assume his electoral campaign, he was succeeded by Pedro Aspe, who was a key member of his technocratic group, and was to become his Finance Minister.

<sup>23</sup> With the disappearance of SPP in 1992, Ernesto Zedillo was appointed Public Education Minister

<sup>24</sup> See Rothstein, 1992 on how institutions are modified by decision-makers as a strategy to enhance their margin of manoeuvre.

<sup>25</sup> Some duties in several public agencies in charge of providing social services were also privatised. Such is the case of the IMSS, where part of the cleaning and garbage collection services were privatised.

<sup>26</sup> At the end of 1994, in a context of political and economic crisis, the technocratic team's cohesion weakened. Although Carlos Salinas had been the group's leader since 1985, and had designated President Zedillo as his successor, he was forced to leave the country following the economic crisis of 1994. The technocratic group he had led was partly dismembered and cut ties with him. Former Finance Minister Pedro Aspe, who had been crucial in the structural adjustment process, retired from government. Finally, President Zedillo's first appointed Finance Minister, Jaime Serra, was forced to resign as a result of the economic crisis.

<sup>27</sup> The only other major reform that was approved was that of the Judiciary, approved in December 1994, and discussed in a previous section.

## **Chapter 6. The Policy Process**

### **6.1 Introduction**

This chapter describes Mexico's process of health reform spanning from 1992 to 1999. The background offers a brief profile of Mexico's health care system from the view of the political context described in the previous chapter. And refers to a reform attempt made at the initiative of the technocratic government in the mid 1980's. The rest of the chapter is organised in the sequential order of a policy process: problem definition and reform formulation, reform legislation and reform implementation. The final remarks present the key policy nodes and the interaction of the actors involved in the process.

### **6.2 Background<sup>1</sup>**

It has been argued that, in Mexico's public provision of social services, politics determine who obtains what, when and how (Ward, 1994). Health and social security services focused primarily on the urban formal workers that were members of the official labour unions, and other strategic groups such as oil workers, the army, the navy and the state bureaucracy. Non-mobilised groups working in the informal economy, particularly those in the rural sector, had access to second-rate public health services and in remote areas, to no services at all (Frenk et al., 1994).

Mexico's health system was organised as such in the early 1940's, with the founding of the Ministry of Health (SSA) and the Mexican Social Security Institute (IMSS). These agencies were established as part of the state's institution-building process around its political and economic priorities. It was during that decade that the Mexican political system was consolidated around a corporatist arrangement. The public health-care services provided by the MOH were aimed at the general population. The IMSS offered a parallel system with exclusive social-

security services for formal workers financed by a tripartite contribution from the government, the employers and the employees.

Using the occupation criteria to determine a citizen's access to health services has produced the division of the system in three clearly differentiated and vertically organised sectors: The IMSS; the Health Ministry and the private sector, each catering to a distinctive group of the population and each pursuing independent regulation, financial and health services provision activities.

Figure (6.1) borrows a diagram from the MOH reform program (1995) that presented the different providers of Mexico's health care system and their target population. The population has been divided between those covered by a health insurance plan – private or public – and those who do not have a health insurance plan and are entitled to public health facilities. A line depicting level of income has been added to highlight how income is a determinant of the type of service a user can access<sup>2</sup>.

**Figure 6.1: Insured and Uninsured Population by Income Level**

Coverage	<b>Insured</b>		<b>Uninsured</b>		
Institutions	Private Insurance	Social Security IMSS & ISSSTE	Ministry of Health	IMSS Solidaridad	No access to health services
Population in millions	47		26	9	10
	High income		Low income		

Source: Ministry of Health, 1995

The relevance of the IMSS as a centrepiece of the corporatist arrangement with politically organised societal groups was clear from the start. Per capita public resource allocations favoured IMSS affiliates disproportionately until the mid-1990's. Governments turned to the IMSS to maintain and expand health-care coverage, and also protected its financial equilibrium in times of economic crisis. On the other hand, the Ministry of Health suffered a series of important budget cuts and remained under-funded until the 1990's. With its funds, and the use of pensions funds, the IMSS built an important health infrastructure in urban and industrial areas<sup>3</sup>. This infrastructure, plus its financial autonomy vis-à-vis the government – due to employer-employee mandatory contributions – helped it maintain its predominant role in Mexico's health sector. Throughout the years, the IMSS' bureaucracy – through the IMSS' union (SNTSS) – became a powerful group due to its role as mediator between formal workers and PRI politicians. Its network included officials within the Executive, the Legislature, and state and local governments.

### **6.2.1 A First Attempt at Health Reform in The 1980's**

As part of the state reform effort that accompanied structural adjustment in the 1980's, a health system reform was started during the De la Madrid administration (1982 – 1988) to raise the efficiency and quality of services, and to improve equity in access to them. It included the decentralisation of the Ministry of Health's facilities and the formation – via the merging of rural IMSS services and MOH facilities and the creation of autonomous state-level health systems. These health systems were going to be created with the decentralised MOH facilities and those of the IMSS it used to serve the uninsured population – thus it would imply passing over IMSS facilities into the control of local decentralised HMO facilities. It also sought to strengthen and increase the decision-making and leadership capacity of the Health Ministry as head of the health sector. These two components of the reform would have implied a change in the balance of power between the MOH and the IMSS, since while formally the Ministry of Health was

the head of the health sector, the IMSS outweighed it in the financial, organisational and political fields.

However, as the economic crisis worsened, the government was forced to reconsider its reform priorities in the public agenda. The president and his economic team focused their attention and political capital on limiting the economic crisis and accelerating structural adjustment in key areas such as the privatisation of state enterprises and the trade liberalisation. As a result of the IMSS' stark opposition to the health reform agenda and the economic crisis reaching a peak in 1985, the De la Madrid government took the decision to bring the decentralisation process to a halt with only 17 out of the 31 states having completed the process.

### **6.2.2 The Health Sector Reform Program (PRSS) 1995 - 2000**

Although initiatives to reform the health sector began to be discussed from the early 1990's, it was only in 1995 that the Health Sector Reform Program (PRSS) was presented as part of the National Development Plan. It was a very ambitious program that considered a long-term horizon spanning across more than the administration's six years. Regarding health services provision, both the National Development Plan and the health reform initiative identified the segmentation of the health system and the division of the target population according to occupation as an issue to be addressed, and both stated that, in the long run, a health care system divided according to functions was desirable<sup>4</sup>.

The Reform Program of the Health Sector stated the following fundamental goals<sup>5</sup>:

- To establish instruments that promote quality and efficiency in the public provision of health services.

- To expand social-security coverage through mechanisms that make affiliation easier for the uninsured population and for those belonging to the informal economy.
- To decentralise MOH health-care provision to those states where it was still centralised.
- To expand health-care coverage to the very poor in rural and urban areas.

Regarding the decentralisation process, the Program stated that the decentralisation of federal resources allocated to MOH services – which had been stopped in the mid- 1980's – should be reactivated, along with the creation of state-level health systems. While the decentralisation of MOH facilities did take place, the merging of IMSS facilities into the new state-level health systems did not occur. Instead, the IMSS pursued its own internal deconcentration process through the creation of seven regions with autonomous responsibilities and functions.

Finally, in order to reach the close to 10 million people with limited or no access to health care, the Reform Program proposed the implementation of a “basic health- care service package” composed of essential cost-effective health interventions with high impact<sup>6</sup>, under the responsibility of the MOH.

### **6.2.3 The Social Security Reform**

The reform of the health component of social security was formally considered as part of the sector-wide Health Reform Program (PRSS) under the leadership of the MOH. However, the IMSS' autonomous status and its political and organisational strength relative to the rest of the sector gave it enough leeway to define and implement its own reform agenda away from the MOH's influence. Thus, while formally the IMSS was required to discuss policy guidelines with the Minister of Health, in reality it negotiated its policy agenda directly with the core ministries – notably with the economic team at the Finance Ministry and the Office the Presidency – as well as with state and local governments. It also managed its own

direct contacts with other actors in society, particularly with organised business and labour which, being affiliated to social security, were part of the Institute's board. The IMSS also conducted its own public opinion strategy around its reform, in which it presented itself as an actor independent of the rest of the health sector.

Another phenomenon that moved the locus of decision-making related to the IMSS' reform further away from the MOH and closer to the Finance Ministry, was the fact that the economic team considered the IMSS' pensions reform a part of the economic reform. The economic team felt that the economic reform had been mostly completed, and was turning its attention to the reform of public social-service provision as part of an effort to preserve the equilibrium of public finances. The IMSS' reform bridged the government's reform agenda from the economic sphere to the social sphere, in that it had a key element related to economic policy – pensions – and presented – in the view of the economic team – the challenges the state faced in relation to social policy: the IMSS' financial viability was at risk as a result of inefficient resource management and the demographic and epidemiological transition of its target population<sup>7</sup>, it presented inefficiencies in health service provision, and had an oversized bureaucracy that centralised the Institute's administration. Its personnel management – which included doctors – was hampered by inadequate performance incentives, a rigid collective labour contract, and complex labour relations with the IMSS' union.

The IMSS' policy problems subject to reform were articulated along the lines of the economic team's financial perspective, with the problems related to service provision proper playing a secondary role. In regard to pensions, the economic team's perception was that employer quotas were high – by world standards – and that this was putting local producers' competitiveness in the world market in jeopardy. According to this view, high quotas were also leading to under-declaration, lack of incentives to create formal employment and fraud. By the mid 1990's, the pensions fund showed severe financial imbalances. Its reserves had been depleted as they had been used to cost IMSS infrastructure and to meet the

running costs of defaulting health services provision. As a result, retirement pensions were being met with active workers' quotas. However, this solution was untenable in the long run due to the changing age structure of formal workers – due to increasing life expectancy<sup>8</sup>.

The IMSS' health service provision also presented serious financial challenges. The original quota had been calculated on the basis of costs of service provision for workers alone, and not for their families. But health service provision had been extended to cover worker's relatives without a matching modification of this original amount. Over time, benefits in health care were also increased without adjusting the quotas, furthering the financial imbalance. This was further aggravated by the fact that quotas were indexed to wages, and not to costs<sup>9</sup>. The financial gap had been met with cross-subsidies from the pensions fund.

The economic team's neo-liberal ideology also permeated the solutions set forth for the restructuring of the pensions system and the IMSS as a state agency, focusing on the privatisation of the former and the financial re-engineering of the latter. The resulting pensions reform proposal consisted of replacing the government's pay-as-you-go pensions system with a private scheme of fully funded individual retirement accounts. Policy to improve the IMSS' health service provision was formulated with the premise that efficiency and quality could be triggered by market (or quasi-market) mechanisms and competition. As a result, the reform proposal was based on changing the Institute's rules and incentives in health service delivery, and on contracting out with private providers in specific areas.

Lastly, the fact that only a part of the population had access to the IMSS' health services – limited to formal workers and their families – was also addressed, although without the same urgency. It had become clear that the inertial expansion of the IMSS' coverage through the obligatory incorporation of new families into the formal work force would be very slow, since the creation of formal employment was very slow due to the economic crisis. Therefore, for the first



time, the possibility of incorporating non-formal workers on a systematic basis through a voluntary insurance scheme was considered<sup>10</sup>. To that end, the Program considered the need to reform the Social Security Law in order to create a Family Health Insurance (SSF). Through this new health insurance scheme, the state would allocate a per capita subsidy financed with public funds directly to informal workers willing to affiliate by paying an annual fee. In this way, the population groups that had purchasing power, but that did not belong to the formal economy, could be incorporated into social security.

The stated goals of the IMSS reform were:

- To privatise the totality of the pensions system to ensure its financial viability and promote the country's internal savings<sup>11</sup>.
- To reorganise the financial structure of the IMSS to guarantee the agency's financial equilibrium with the elimination of cross-subsidies and adequate quota levels<sup>12</sup>.
- To improve the quality of health care provision through the introduction of measures such as doctor eligibility at the first level, permanence and productivity incentives, and the application of the opt-out option for those business willing to contract private health care services for their employees.

### **6.3 Problem Definition and Reform Formulation (1992 –1994)**

From the early 1990's, a variety of groups in society and within the state started to consider different policy options for reforming the health sector in its totality, or in one of its central components: the health services provided by the IMSS to little less than one-half of Mexico's total population. These groups' initiatives, and indeed their own nature, changed over time as the process of health reform unfolded; but based on the basic characteristics of their proposals, and the position in the political context where they operated, they can be divided into three.

First, the technocratic group which from the government's economic team, which was assigned to the IMSS' Financial Division, and whose proposal was to prevail, influenced from the other two groups. Second, CEDESS, IMSS' think tank created to support the IMSS' Directive's decision-making, which lost the battle to define the content of the reform, but was indispensable to making the first group's technocratic proposal politically feasible. Third, a heterogeneous group formed by a private think tank representing the interests of the business community (Funsalud) and another made up of members of the Ministry of Health<sup>13</sup>.

### **6.3.1 The Economic Team and the IMSS Reform**

The IMSS was regarded by the economic team as a large government agency in financial difficulties that needed to be reformed as part of the efforts to bring the state's finances back to equilibrium. Responding to what was seen as an imminent crisis, members of the economic team in the Finance and Commerce ministries started studying the case and formulating policy proposals from the early 1990's. Pedro Aspe, the Finance Minister, assigned a group of young officials the task of exploring different policy options to solve the IMSS' imminent financial crisis and to design a new pensions scheme. Although some IMSS officials participated, most of the research and the resulting reform proposals stemmed from the Finance Ministry and the Central Bank (Bank of Mexico). Emilio Gamboa Patrón, the IMSS' Director at the time, was kept informed of the project's development, but neither he nor his collaborators were directly involved.

The Finance Ministry's proposal was not the only one that was formulated within the Executive. The IMSS issue was relevant enough to become an element of competition among the economic team's factions, which were positioning themselves to compete for the presidential succession<sup>14</sup>. Thus, in a parallel way, the Chief of Staff of the Presidency entrusted public officials from the Commerce Ministry with working on an alternative proposal (Interview, 04/08/99). The Finance Minister's team finally lost control of the project, which was assumed by the Finance Vice Minister, Guillermo Ortiz – who belonged to the president's

chief of staff's *camarilla* – and his team with the close collaboration of the officials at the Commerce Ministry.

As the reform proposal took shape, some of the members of the technocratic group that had gained control over the project were assigned to positions within the IMSS to work on its technical details and prepare for its implementation – which was planned to take place during the following administration. Among them, Gabriel Martinez, an economist who, as a junior member of the economic team working in the Commerce Ministry, had participated in important deregulation projects<sup>15</sup>, and was aware of the discussions around the IMSS reform. At Commerce Minister Serra Puche's recommendation, he was assigned to the IMSS' Financial Department, to a position whose appointment was in control of the Ministry of Finance<sup>16</sup> (Interview, 02/24/99). When President Zedillo was elected, it became clear that Minister Serra Puche would become the future Finance Minister – as indeed happened – and thus Gabriel Martinez and his team counted on direct political support from the Finance Ministry – a key vertical network. However, this change team was soon to lose its single most important vertical network with the resignation of Finance Minister Serra Puche within weeks of President Zedillo' taking office.

### **6.3.2 The IMSS Attempt to Retake Control**

The take-over of the project by this new faction of the economic team coincided with a change in the IMSS leadership. Emilio Gamboa Patrón was replaced by Genaro Borrego Estrada as the Institute's Director. Borrego's arrival at the IMSS represented a breaking point in the reform process. Although not a technocrat, and with a long political career in the PRI, he presented himself as a policy-maker with a combination of political and technical skills, capable of bringing about the social security reform. Contrary to his predecessors, he decided to participate directly and actively in the restructuring of the social security system. In order to do this, he sought to generate a technocratic reform proposal of his own that would differentiate itself from the economic team's proposal by looking beyond

the IMSS' financial aspect and present a comprehensive reform of the IMSS (Interview, 03/22/99).

For this purpose, and before the economic team assigned Gabriel Martinez to the IMSS' financial division, he created a think tank in mid-1993, called *Centro de Desarrollo Estratégico para la Seguridad Social* (CEDESS) with a group of economists and actuarial experts with similar technical training and ideology as the technocrats in the Ministry of Finance. CEDESS was assigned the responsibility of studying policy options and to formulate an integral reform proposal which included an in-depth change in health service delivery. It was formally separated from the IMSS, and in practice operated as a think tank for the Institute's management. The CEDESS team was in charge not only of presenting a technocratic proposal in similar terms as that being prepared by the economic team in the core ministries – thus facilitating closer links with this group – but also of creating the means to have the IMSS reform process gravitate back to the IMSS' control.

For many months, there was extensive exchange of information and analysis<sup>17</sup> between the members of the economic team and CEDESS. But this did not develop into a co-operative relationship on an equal basis and only the few members of CEDESS who were also close collaborators of the economic team circulated freely from one team to the other. In the end, while most of the actuarial work and part of the economic analysis was carried out at CEDESS, the economic team and later on, the IMSS change team, were in control of policy decision-making.

Between 1993 and 1994, the CEDESS team worked on a series of projects regarding the IMSS reform agenda with a wide range of policy options – from the most radical which relied on the market to the most moderate which preserved a central role for the state. Among the studies prepared by this group, the most important were the *Proyecto de Gran Visión* and the *Proyecto Águila* stemming from it<sup>18</sup>. In them, the CEDESS team compiled its assessment of social security in

Mexico and its reform proposals. For the IMSS' health component, the *Proyecto Águila* had, among its objectives, the need to achieve the financial self-sufficiency of the IMSS' health service provision, to increase quality and efficiency in service delivery, and to expand coverage to all the employed population regardless of their status of occupation – both formal and informal<sup>19</sup>.

To attain these objectives, the document proposed the reorganisation of the IMSS' health care financing and service provision and the creation of a health insurance scheme for families not affiliated to social security. To achieve the IMSS' health services' long term financial equilibrium – and boost producer competitiveness – *Proyecto Águila* suggested an increase in the state's share of the tripartite social security quota equivalent to a decrease in the employer-employee share. This decrease was also expected to make the implementation of the opt-out option feasible, without putting IMSS finances at risk. The project also sought to eliminate cross-subsidies from the pensions fund into the IMSS' health care services – which had been used as a strategy to maintain their finances afloat – in preparation for the privatisation of the pensions scheme.

With regard to measures to improve quality and efficiency in health care provision, *Proyecto Águila* proposed doctor eligibility at primary level, and recommended both expanding doctor choice to private providers that complied with the Institute's requirements, and changing IMSS doctors' remuneration from salary-based to capitation, thus in practice opening IMSS services to public-private health service provision and introducing competition. Along these same lines, the document suggested that support services such as pharmacies, laboratories and radio diagnosis be contracted out – to providers operating independently or in IMSS facilities.

In spite of CEDESS' collaboration with the economic team and the change team at the IMSS' Finance Division, the IMSS Director's attempt to take control of the reform's formulation failed. The IMSS Directorate was only given a major role when the economic team had finished its own reform initiative, and needed to

broker it with key interest groups – notably business and labour, and the IMSS union - and in Congress, when the bill was submitted for legislation. Some significant changes were made to the economic team's reform proposal based on the IMSS Directorate's arguments on political feasibility during negotiations with different actors throughout the reform process, but the project remained firmly in the hands of the economic team, who saw in Martinez' change team an extension of its own.

Thus, under the control of the economic team, the reform of the IMSS' health services had two characteristics that relate them to the economic team's social-sector reform agenda. First, it could be considered as an extension of the financial restructuring of IMSS insurance funds into the daily operative process of IMSS health services; and second, it followed the principles used by the economic team in social sector reform – rationalisation of expenditures, targetting, and performance incentives among others. Also, in contrast to the pensions reform, most of the policy changes related to the health component could be pursued through internal administrative acts and decrees within the IMSS, and without the need to amend the Social Security Law. This meant that there were few institutional requirements for consultation and policy dialogue with the health sector's interest groups, and that its timing did not have to abide by the legislative calendar.

### **6.3.3 Other Groups Influencing Reform Formulation**

In preparation for the change of administration, other groups in society and within the state started studying and preparing policy proposals for health reform. Among these, two groups competed to influence policy decision-making and position themselves to head the MOH. One stemmed from the Planning Division of the MOH, and the other from the private think tank Funsalud.

In the quest for the position of Minister of Health, the Ministry's Planning Vice Minister led his team into conducting a series of polls to build a database for a

health reform plan. His group also published, as part of MOH publications, a series of small booklets addressing some of the issues relevant to the health sector. However, these publications did not form a single body forming a health reform proposal<sup>20</sup>. As part of its political agenda, this team participated in a group organised by the PRI – called Grupo Coordinador en Salud – with the task of putting together a white paper on health as part of the PRI's electoral platform for the presidential race. However, when the team's leader was not assigned to the MOH, it was dismantled and its members resumed research activities at the National Institute of Public Health.

Funsalud conducted a two-year project funded by the business community called Health and Economy. This group produced a comprehensive health sector proposal that envisioned major changes in both the Ministry of Health and the IMSS, aimed at establishing a single system with a plurality of public and private health service providers, where the Ministry of Health would be responsible for policy guidelines and regulation, while the IMSS would be in charge of health service financing. Health service provision was to be left to a plurality of public/private actors.

Funsalud's project was the first case in which a very visible and comprehensive policy proposal was presented to the public arena by the private sector through a group of businessmen who aspired to influence the public-policy agenda in the area of health. This group was dissatisfied with the financial burden that the social security obligatory contributions put on the private sector, and by the poor quality of the services received by their labour force. Thus, they funded Funsalud's *Economía y Salud* project with the aim of presenting, in an articulate manner, elements regarding the why and how of the need for IMSS reform – particularly its downsizing and the possibility of replacing its services with public/private health care via the opt-out policy.

The project's leader, Julio Frenk conceived the idea of the *Economía y Salud* project when he collaborated in the preparation of the World Bank's World

Development Report 1993, which had health as its main topic. Thus the *Economía y Salud* proposal went beyond an assessment of IMSS performance, and addressed issues central to the entire health care system, such as equity, efficiency and quality; and presented policy solutions along the lines that were being discussed in the international arena, such as the health care system's reorganisation by functions, quasi-market and competition elements to induce efficiency and better quality of care.

As the proposal was being prepared, the businessmen supporting Funsalud lobbied in favour of their health reform agenda, resorting to direct contacts with members of the government's economic team, who shared the same ideology and were studying policy options in the same field. Funsalud's draft proposal was presented to the faction led by the Finance Minister, then in control of the government's social security reform project. The minister responded making information available to Funsalud, and a discrete policy dialogue was initiated. The Finance Ministry team found in Funsalud a space outside government and insulated from interest groups, in which different reform proposals could be studied and debated with no constraints or political considerations.

By these means, Funsalud was successful in permeating the state's decision-making on the health reform agenda. Also, through an accompanying strategy of policy dissemination – including seminars and publications – the *Economía y Salud* project managed to put the health issue on the public agenda and to articulate the policy debate around the reform – with positions against and in favour of it<sup>21</sup>. But when the Ministry of Finance faction lost the project's control to its rival faction within the economic team, Funsalud lost its close contact with government decision-makers and with it, the possibility of influencing the reform's implementation plans.

In 1994, as the presidential elections came closer, the PRI invited Jaime Sepulveda's team, the *Economía y Salud* team, CEDESS, and Juan Ramon de la Fuente, Director of the National University's Medicine Faculty, along with other

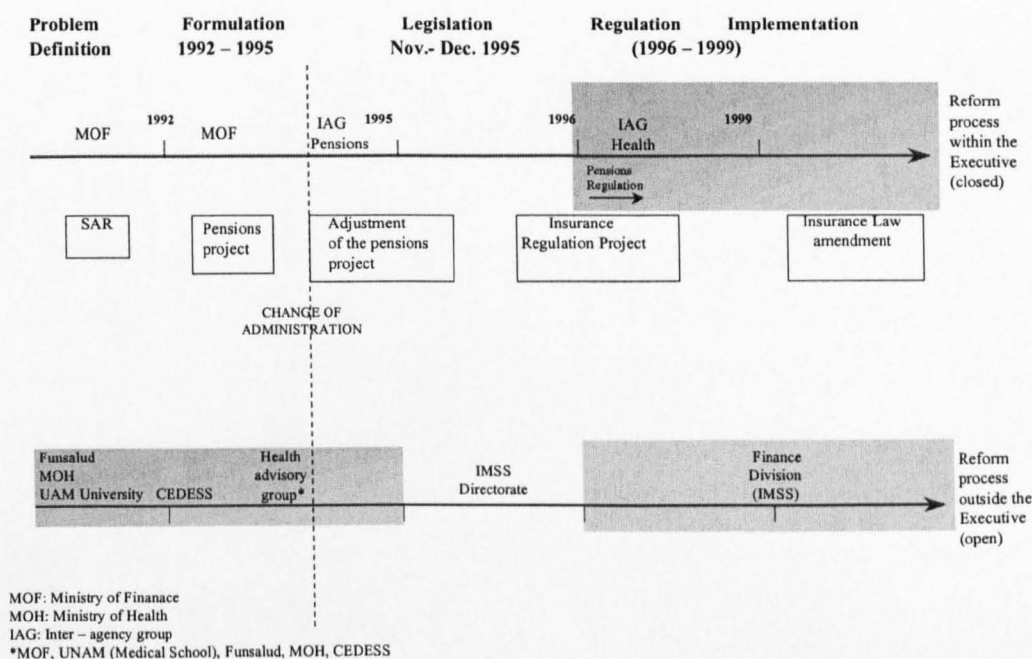


public officials, to organise a group called *Grupo Asesor en Salud* and prepare a health *white paper* to be incorporated into the PRI's political platform for the presidential campaign. This group worked for many months on a policy proposal<sup>22</sup> and competed to have control over its end result. It also strove to establish closer links with the technocratic faction of the economic team which was now in charge of the reform proposal, and was working on presidential candidate Zedillo's government plan in a parallel arena to that of PRI politics.

In spite of these efforts, the reform's content remained firmly in the control of the economic team. This group took Funsalud's input, as well as the white paper's, but did not establish a policy dialogue with any of the teams that had prepared them. Instead, it continued to conduct its own analysis of other countries' experiences in the field of health care reform and decided on the reform's content, scope and timing in an isolated manner away from the public policy debate arena in which the other groups were operating.

In retrospect, two different arenas where policy debate around the reform was taking place can be singled out. Figure (6.2) shows, in the top track, the insulated policy arena where the different technocratic factions discussed and competed to control the health reform project away from the debate and competition that was taking place simultaneously in the somewhat more open – if still very exclusive – arena, with the participation of social and other state groups – represented in the bottom track. While the overall aim was social security reform, the content of the proposal varied according to the arena in which it was discussed and negotiated. The grey areas show the moments at which the health aspect of social security was discussed in both arenas. Given the political power of the economic team, the content of the resulting reform gravitated mostly around economic and financial issues, whereas the reform of the health component was only central to the more open arena involving state and societal actors related to the social sector.

Figure 6.2: Parallel Arenas in the Reform Process



#### 6.4 The Reform Agenda in the Light of the Change of Administration and the 1994 Economic Crisis

At the end of the Salinas administration, the economic cabinet studied the reform proposal prepared by CEDESS. Given the proximity of the change of administration, it was decided that further formulation and eventual implementation should take place during the incoming Zedillo administration. President-elect Zedillo asked Borrego to remain as IMSS Director and to develop a political strategy to implement the reform (Interview, 05/05/99). Gabriel Martinez and his team had already been appointed to the IMSS' Finance Division with the political backing of the newly appointed Finance Minister.

At this moment of government transition, a certain balance persisted between the reform objectives related to pensions and those related to health services. These were: the increase in internal savings through the privatisation of the pensions system; stabilising of the IMSS' finances through the financial re-engineering of

the Institute's core insurance funds – pensions and the health component – and the expansion of and improvement in quality of the IMSS' health care services. It was clear that the aim was to carry out an integral reform. One that would imply the transformation of the IMSS (the old actor in the health care system) and the creation of new societal, such as HMOs that would cater for IMSS affiliates who decided to take the opt-out and quota reimbursement option described above.

The incorporation of Gabriel Martínez into the IMSS was seen as a signal of the Zedillo administration's resolution to implement the social security reform. However, in spite of these preparations and the existence of a virtually complete reform proposal, the economic crisis in which the country was engulfed within weeks of the new government's taking office, and the legitimacy crisis that it thus endured, forced it to revise its reform agenda, including that of the social security's integral reform.

The Finance Minister, Jaime Serra Puche, was made to resign less than a month after he had been appointed. However, he managed to negotiate for his collaborators to remain in their posts in different ministries (Interview, 02/24/99), thus Gabriel Martínez and his change team, though deprived of their most important vertical network of support, remained in the IMSS and continued to pursue their reform agenda, if under much more constrained circumstances.

The urgency to bring public finances back to equilibrium reinforced the new economic team's perception of the need to restructure the pensions system. The re-engineering of the IMSS' finances was also perceived as indispensable, since the decrease in employer-employee quotas – due to the drop in formal employment – were putting them under severe strain (Interview, 04/13/99). But the reform of the IMSS' health services did not represent an equally urgent challenge and resources to cover its transition were not at hand (Interview, 04/22/99).

Thus, as an outcome of the December 1994 economic crisis, the reform of the social security's pension scheme gained priority status on the public agenda, but simultaneously, the impetus for an integral reform that would pursue the IMSS' pensions and health provision reform simultaneously, was lost. By early 1995, the Zedillo government had decided to concentrate its political and economic capital on the pensions reform and the re-engineering of the Institute's finances, and left the health component for a second stage. However, there were several attempts at reincorporating the health reform in part or in its totality, and a few elements – notably those that did not require an open confrontation with the IMSS' bureaucracy and its union, did reach implementation stage.

#### **6.4.1 Negotiations within the Executive (1995)**

In spite of the reform definition that took place since the early 1990's, the formal process of amendment of the Social Security Law began with President Zedillo's speech at the LXXVI IMSS General Assembly, on the 25th of January, 1995. In his message, he summoned the Institute's community to carry out an assessment of the IMSS, and invited different societal groups, particularly workers and employers, to participate in the debate. Given that at the time of this invitation the government already had a social security reform proposal, this exercise aimed more at complying with a formal exercise of policy dialogue, than with promoting these groups' real participation in policy decision-making.

In March 1995, less than two months after the president had formally convened all groups to participate in the IMSS' assessment, the IMSS Directorate presented a document called *Diagnóstico*. IMSS officials describe it as the “public relations” version of the the IMSS reform contained in the *Proyecto Aguila* prepared by CEDESS in 1994 (Interview, 10/06/99). Divested of all the technicalities, it stated in simple direct terms, the problems faced by social security and the Institute's administrative difficulties. The document defined the IMSS' policy problems in a way conducive to having the *Proyecto Aguila* reform proposal as their plausible solution. Under these circumstances, when the *Diagnostico* document was made

public, the IMSS union immediately rejected it on the grounds that it had been formulated without its participation (Interview, 05/05/99).

As soon as the IMSS' *Diagnóstico* became public, the Institute's Directorate began to implement a series of political strategies aimed at overcoming possible resistance and trying to avoid the formation of a coalition of resistance led by the IMSS union as had been the case a decade earlier. A media campaign was launched to inform public opinion about the IMSS situation and the need to carry out the reform. Information was oriented towards presenting the government's reform project as the best possible option, seeking the support of public opinion (Interview, 05/05/99). Simultaneously, negotiations were started with the business and labour organisations – notably the CCE and the CTM.

The publication of the *Diagnóstico* document was soon followed by another IMSS document, called *Hacia el Fortalecimiento y Modernización de la Seguridad Social* <sup>23</sup> in mid-1995, which presented the reform's policy proposals in detail. The comparison between this document, and the 1994 *Proyecto Águila*, clearly shows how the government's intent to reform the IMSS' health component along with pensions had dwindled, reducing health reform to little more than the reformulation of the tripartite quotas for this insurance fund and the expansion of coverage through the creation of a Family Health Insurance (SSF) by which informal workers and their families could have access to health care through a voluntary and partly subsidised health insurance scheme. The controversial opt-out and quota reimbursement policy – which if applied systematically would bring about the IMSS' most significant transformation – remained as part of the proposal – albeit without acknowledging the need to establish clear and non-discretionary regulations for that purpose.

At around the same time as the *Diagnóstico* document was made public, the *Proyecto Águila* was presented to the new economic cabinet. The cabinet appointed pensions and health committees – composed of representatives from various ministries, such as Finance, labour, and the IMSS – to refine the reform

proposals (Interview, 05/11/99). The points of dissension were negotiated in the following months within these cabinet technical committees away from public scrutiny<sup>24</sup>. It was during this period of reform formulation and negotiation within the closed arena of the Executive power that a deliberate decision was taken to exclude any element concerning the restructuring of the health component of Social Security from the bill, and to include only the changes to the pensions system and the financing regime of the funds. It was at this moment that the CEDESS' more integral proposal lost to the more narrowly defined economic team's. The health care reform was abandoned at that moment because it was thought that including an additional element in the bill would burden the policy agenda, and the political feasibility of the priority reforms would be put in jeopardy (Interview, 04/13/99). Thus, without direct pressure from groups against the IMSS' health reform, the economic change team chose to discard it in order not to saturate the policy agenda and avoid a political confrontation that could jeopardise the pensions reform.

However, for the economic team – and CEDESS – the discarding of the reform's service provision components from the bill to be submitted to Congress did not mean an immediate stop to their actual implementation. Rather, as a second option, the economic team decided to let these policy changes be pursued through administrative acts and by putting into practice the old IMSS Law's articles<sup>25</sup> (Interview, 04/16/99). In other words, the economic team resorted to implementing the health care reform through modifications to internal rules and regulations, without changing the Law, and in doing so, limiting the further politicisation of the entire reform. With this strategy, negotiations around this part of the reform were transferred away from the legislative arena where it would be open to the influence of many actors, to the IMSS' internal arena, where the process was exposed to the influence of fewer actors, albeit among them, the powerful SNTSS.

The final reform package of IMSS' health component included a series of elements, six of which were related to the rationalisation of resource management

for the sake of a more efficient use of resources. At the same time, many of these policy proposals were linked to the Zedillo administration's health reform program (PRSS). Notably, the creation of the Family Health Insurance, aimed at expanding the social security's health component's coverage through a health insurance scheme for workers in the informal economy. The reform initiative related to the systematic application of the opt-out option that would have triggered the transformation of IMSS and given the incentives for the creation of the new providers in the sector – the HMOs – was not included in the reform package, but remained present as part of the Social Security bill that was submitted to Congress.

#### **6.4.2 Opening the Process? A Forum for Consultation (Late 1995).**

Once the content of the reform was agreed upon in the cabinet technical commissions within the Executive, labour and business leaders, together with public officials, were invited to participate in a forum to discuss the reform as part of the formal reform process called *Comisión Tripartita para el Fortalecimiento del Instituto Mexicano del Seguro Social*.

Although the formal objectives of this forum's seven technical commissions were to analyse the IMSS' policy problems, and to study different policy options to solve them, the exercise was directed towards what had already been decided within the Executive (Interview, 04/15/99). On November 1995, the *Comisión Tripartita* presented to President Zedillo its final document called the *Propuesta Obrero-Empresarial de Alianza para el Fortalecimiento de la Seguridad Social*<sup>26</sup>. Although it was a joint labour-business-government document, the proposal clearly reflected the government's policy priorities. Thus, as a result of its deliberations on the IMSS' health component, the tripartite technical commission stated the following fundamental goals: to reach universal coverage, attain financial self-sufficiency, and improve the quality, efficiency and satisfaction of service provision. The concrete measures to improve the quality of the service were: doctor eligibility, capitation, and permanence and productivity incentives<sup>27</sup>.

It also recommended an increase in the government's quota share and the systematic implementation of the opt-out and quota reimbursement mechanism.

The formulation of the reform proposal was formally attributed to the *Comision Tripartita*<sup>28</sup>, but its capacity to influence the reform agenda was limited. More than a real negotiation and consensus-building, it was an exercise with which the government fulfilled the requirements of the sectors' participation in the process. The intention was to present the document as a labour-employers' proposal to weaken possible SNTSS arguments against the reform, when in reality it had been previously negotiated with the CTM and the CCE (Interview, 05/05/99). Once the president gave his approval to the reform proposal, the process was opened to participation by a wider group of actors. Negotiations within the Executive halted and lobbying started in preparation for submitting the bill to Congress (Interview, 05/05/99).

#### **6.4.3 Legislation (November - December 1995)**

The IMSS director, Genaro Borrego who had been given the task of negotiating the Executive's reform initiative with labour, business, and the IMSS' union, was again commissioned to lobby it in Congress. It was his political brokerage experience – as former PRI president, former governor, and former PRI Senator – that gave political feasibility to the technocratic reform proposal prepared within the Executive. In the Legislative arena, the SNTSS, the main actor lobbying against the reform proposal, was able to exert a significant degree of veto power through its influence on legislators unwilling to come to odds with organised labour. But this proved to be insufficient to veto the pensions reform, which was a priority for the Executive.



On November 9, 1995, President Zedillo submitted the initiative for the New Social Security Law to Congress. The pensions component of the reform proposal in the initiative was very similar to the one formulated in 1994 in *Proyecto Águila*; but the health services component had been significantly reduced. The items that required the modification of the IMSS' collective labour contract, or that could have an impact on IMSS personnel's labour conditions, were removed from the initiative. Such was the case of the doctor eligibility initiative and the modification of doctors' pay to introduce incentives for permanence and productivity and eventually for a capitation system. At this stage, the bill still contained, along with the modifications to the tripartite quota that would bring fresh public resources to the Institute and the creation of the Family Health Insurance, the amendment for the more systematic implementation of the opt-out policy, leaving open the possibility of the introduction of public/private provision of services.

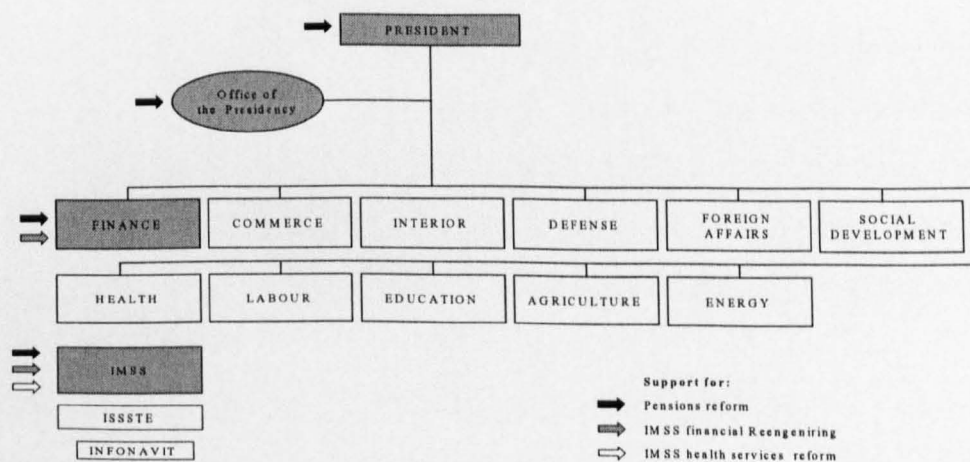
The limited nature – in number and scope – of these proposals geared to reforming the IMSS' health services, suggested that the idea of an integral IMSS reform was abandoned before it was formally submitted for legislation. Following its lobbying and negotiations in Congress prior to the reform initiative's formal presentation, the IMSS Directorate concluded – and warned the economic team – that if the health component was included in the bill, the IMSS reform would not be approved in the Legislature (Interview, 04/13/99). So given that the economic team's – including the president's – central objective was to ensure approval of the modifications to the pensions system and the Institute's financial regime, the initiative was almost divested of its health component.

The importance of each of the reform's components – and thus their probability of being included in the bill – could be traced back to which actors supported it, and to what extent. In the case of the pensions reform, it was clear to all actors that the president was committed to it, and that to confront this initiative would have been politically very costly (Interview, 04/16/99). In the case of the reorganisation of the IMSS' financing scheme, the thrust of the support came from the Finance

Minister and one of his vice ministers (Interview, 04/16/99). This was decisive for its inclusion in the new Law. Concerning the health component, no one clearly supported its inclusion in the bill. On one hand, neither the Office of the President, nor the Finance Ministry were committed to it. On the other, the IMSS Directorate perceived that it did not have sufficient political capital and enough economic resources to promote it on its own. As one official pointed out, "...to push the health reform forward, it would have been necessary for the president or a minister to support it, and no one did." (Interview, 04/16/99). Likewise, the IMSS Directorate considered that the restructuring of health service provision could be implemented at the administrative level, through the modification of regulations, and without the need for Law amendments (Interview, 05/11/99).

Figure (6.3) shows the sources of support for the different elements of the social security reform initiative. The parts of government that were directly involved are shaded in grey. Note that the pensions reform was supported by all the agencies involved (black arrows). Particularly, it counted on the direct support of the president. The Finance Ministry backed the financial reengineering of IMSS, since it was concerned with the impact of IMSS' financial imbalance could have on the government's deficit. In contrast, the health reform failed to convey the support of the president and the Finance Ministry, and instead, was only supported by the IMSS Directive within IMSS (white arrow).

Figure 6.3: Reform Initiatives and Sources of Support\*



\*Indicative, non comprehensive diagram

#### 6.4.4 Approval in Congress

Before the reform bill had been sent to the Lower House, IMSS Director Borrego, in charge of brokering the reform, perceived resistance from various opposition legislators, and even from PRI legislators, who still resented having been forced to vote in favour of the Executive's highly unpopular proposal to increase Value-Added Tax by 50%, and were thus reluctant to vote in favour of it (Interview, 05/05/99b). In response, the IMSS Directorate mounted a political strategy on different fronts to obtain the bill's approval in Congress. It continued its media campaign to inform public opinion about the reform and generate social support around it. It lobbied in favour of the bill among the corporatist groups representing labour unions, pensioners' organisations and the business community. It also prepared a negotiation strategy around the reform's content that included defining those of its elements that could be left out as a concession to legislators resisting its approval. Along those lines, some government officials suggested that the IMSS Directorate might have recommended the inclusion of the controversial opt-out option in the reform simply as a bargaining chip to be removed as a concession, since it was certain to be a point of dissent (Interview, 05/05/99b).

It sought to establish personal contact with PRI representatives to explain the content of the reform and try to win over undecided members. A number of political operators were co-ordinated by the IMSS' Directorate to lobby in favour of the project within the PRI's legislative fraction. Among them, leaders of each of PRI's corporatist sector. Internal party alliances and political bargaining calculations played an important role at this time. The National Peasant Confederation did not present major resistance to the IMSS reform; however, CNOP members, and specially CTM members, presented a major challenge.

Legislators who belonged to the PRI's labour sector manifested strong resistance to the reform project, especially representatives with links to labour unions. As one PRI legislator put it "PRI representatives do not like to vote against labour

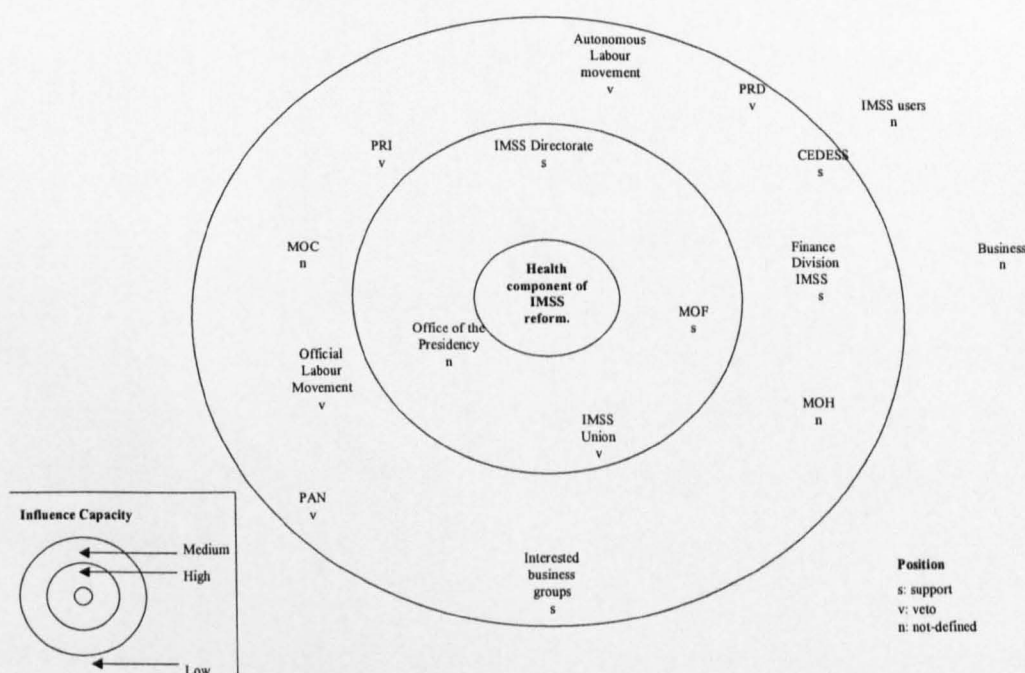
unions” (Interview, 05/05/99). Alejandro Audry, a PRI congressman and Political Action Secretary of the IMSS union, was one of the most fierce and vocal opponents to the reform<sup>29</sup>. The lobbying among congressmen included perks and benefits to individual congressmen (Interview, 05/05/99b). President Zedillo was personally involved in lobbying the National Action Party by holding conversations with the PAN’s president. The PRD manifested its unconditional intention to vote against the project from the moment it was made public.

In spite of this intensive lobbying activity, the Executive’s bill for social security reform faced such opposition in Congress<sup>30</sup>, that only the PRI’s legislative majority – whose members abided by party discipline – granted the fast approval of the New Social Security bill with no substantial modifications. Two of the left-wing opposition parties – the PRD and the PT – opposed the reform on ideological grounds. The PAN’s position was more ambivalent. On the one hand, the privatisation of the pensions system was in accordance with the party’s principles; on the other, PAN legislators were concerned with the political costs their support of the Law’s approval would bring (Madrid, 1998). PAN representatives voted within the party to define the party’s position regarding the reform proposal. In spite of the national party leader’s lobbying effort, only 18 congressmen voted in favour of the reform, 54 voted against it and 19 abstained. Some political observers think that PAN representatives received instructions to vote against the initiative to undermine political support around the PRI (Interview, 04/08/99).

The bill’s final version contained more than 60 modifications, but maintained its original orientation. The most significant modification was the retrieval of the Law amendment referring to the opt-out policy. Seeing that its lobbying strategy to stop the introduction of this component had been successful, the IMSS union pushed negotiations further in order to eliminate the article contained in the old IMSS Law that allowed for its implementation at the discretion of the IMSS’ Technical Committee. But it did not succeed and the new IMSS Law maintained it.

The bill for the New Social Security Law was approved in the Lower House on December 7, 1995 with 289 PRI votes in favour and 160 votes against it. A few days later, it was sanctioned in the Senate, with no modifications, on December 12, 1995. Figure (6.4) diagram shows the position of the different groups that were involved in the approval of the Social Security Law, as well as their level of influence. Each actor's relative distance from the centre represents their relative power to influence the reform's policy content.

Figure 6.4: Legislation Stage (1995) : Political Map



## 6.5 Implementation (1996 – 1998)

After the new Social Security Law was approved in Congress in 1995, the pensions reform implementation was started right away, whereas a transitory article mandated the rest of the reform – related to IMSS' finances and health services – to start implementation in 1997, to allow the Institute to prepare for policy change. Thus the health reform process gravitated back to the IMSS arena

where financial resource reallocation, and the new rules and incentives by which policy change was to be pursued were to be defined. These responsibilities were assigned to the change team working at the IMSS' Finance Division, which continued to work closely with its counterparts in the Finance Ministry. The change team secured an important loan from the World Bank to cover the IMSS' investment needs in infrastructure and to fund the design and pilot implementation of the components of the reform related to health service provision – most of which did not stem from changes in the IMSS law, but could be carried out via administrative acts and changes in the IMSS' labour contract.

But given that IMSS change team had lost its vertical network – which was not replaced by the new Finance Minister – it lacked the political support to insulate itself and the reform from the pressure of the key interest group resisting change: the IMSS union. While it had some control over the financial re-engineering since the complexity of resource reallocation made resistance to it difficult, the change team was forced to negotiate and look for consensus within the IMSS in all aspects related to the implementation of changes to the health services. The fact that IMSS senior level officials were affiliated to the union<sup>31</sup> helped it have access to information and control over decision-making related to policy change – including the co-ordination of the World Bank-sponsored pilot projects and their implementation.

In this competition for control over the reform's implementation within the IMSS, the change team at the Financial Division did not count on the support of the IMSS' Directorate either. Not only had both groups been rivals from the reform's early formulation stages, but the latter continued to see the former as an extension of the economic team, and thus foreign to the IMSS. The change team's orthodoxy in exclusively using technical criteria in policy decision-making, without considering the political dimension of policy change was seen as a potential political problem, since it risked putting the Institute's relations with business, labour, and particularly the IMSS' union – still strained by the recent approval of the reform – in jeopardy (Interview 06/09/99). Moreover, because the

health reform was not a priority in the national reform agenda, and a potential labour conflict within the Institute was always a serious matter for concern – due to its immediate visibility – the Executive's support for this component of the IMSS reform was also minimal.

Also, in the eyes of the Institute's directorate, the urgency to reform the IMSS' health services had ceased, not only because it had lost its political returns – since the quest to take control of the reform by adding this element to it had been lost<sup>32</sup> – but also because the allocation of fresh public resources – due to the implementation of the new quota with a larger government share – had taken the strain off the IMSS' finances in the short term (Interview, 05/11/99). The following diagram shows how the IMSS health service provision solved its deficit as of 1997, when fresh funds were introduced; however, expenditure continued the same trend, reflecting no effective implementation of policy change leading to cost containment in the short run.

But above all, the principal obstacle to policy change once the reform had gravitated back to the IMSS was the IMSS' union (Interview, 05/05/99). The union had regained its position of power since change depended on its membership. The union's political strength was based on a series of factors, including the size and presence of its membership and its average education level – since it incorporated doctors – which allowed it to influence IMSS activities at every level, and to develop a sophisticated alternative policy agenda. Furthermore, the union's political base had expanded and diversified. Its leadership maintained a close interaction with the PRI's leadership, who still perceived it as a key intermediary in state-society relations, and thus an important political player to accommodate to. At the same time, its heterogeneous membership had expanded contacts with other groups with high political mobilisation capacity, such as left-wing parties and guerrilla movements<sup>33</sup>. The expansion of the IMSS as the single most important state provider of health services – catering in many instances to the uninsured population as well – had consolidated the union's presence at the national, state and local levels, where it had daily contact with the population, and

thus the opportunity to generate a base of support of its own. While the union did not make any open threat to mobilise its membership or this base of support against the implementation of the reform, the fact that it had done so in the past – notably during the first attempt at reform in the 1980's – worked as an important precedent.

The union was originally set to protect the IMSS pensions system and maintain its control, but its political strength was not sufficient to confront the economic team's agenda in this area, since the latter counted on the direct support of the president. Thus, it focused on health and other services provided by the IMSS, and saw any attempt at contracting out private providers, or the implementation of the opt-out option and the introduction of the public/private mix in health service provision, as an unequivocal antecedent to the Institute's dismantling or its privatisation. It thus opted for a strategy of no concessions. The union effectively stopped the undertaking of any additional contracts to private providers in non-essential areas, as well as the publication and sanctioning of the regulation package needed to implement the opt-out option. It was also successful in protecting its collective labour contract from any modifications needed to implement some of the elements of the health reform – notably those related to wage incentives towards quality and efficiency and doctors' eligibility.

While the economic team, the IMSS change team and CEDESS effectively isolated the union from reform formulation, and it had partial influence over the reform's legislation, it regained control over the reform once it entered its implementation stage. It is not clear whether the union made any serious attempts at letting itself into the decision-making room during the reform's formulation. Its attempts at influencing the process during legislation were also half-hearted, where it concentrated more on limiting the scope and depth of the reform, than on derailing it all together. It made timid attempts at organising a labour coalition in defence of the status quo – to no avail – and did lobby sympathetic legislators of different parties. However, it stopped short of mobilising its membership or organising a media campaign – with exception of some editorials and articles



accusing the government of attempting to privatise the IMSS. It can therefore be argued that the union chose to wait for the reform to gravitate back to the IMSS during its implementation stage, where it had enough power to preclude policy change from happening.

## 6.6 Another Attempt at Health Reform

A few months after approval of the new IMSS Law, the Executive put together an *ad hoc* inter-agency group – with a similar profile to that of the cabinet’s technical commissions – in 1996, to study the need to regulate the private health sector and the emerging Health Management Organisations (HMO) market called *Instituciones de Seguros en Salud* (ISES). Because this initiative was intrinsically related to the opt-out issue<sup>34</sup>, the long-standing discussion about the possibility of establishing a more systematic opt-out option mechanism for IMSS affiliates was put back on the decision-making table by the economic team in the Executive.

This inter-agency group made up of officials from the Office of the Presidency, the Finance Ministry, the Health Ministry and the IMSS started to work on a policy proposal that considered the possibility of regulating simultaneously the Health Management Organisations (HMO’s) emerging market and the IMSS’ opt-out policy. But once more, the possibility of a confrontation with the IMSS’ union, and its political consequences, led the group to postpone the latter and to carry on exclusively with the former. Yet again, political considerations were not the only concern this group had when it decided to postpone the issue once more. The other reason behind not pursuing this line of policy change was the technocrats’ perception that there was no objective information about the opt-out option and public/private service provisions having a positive impact on the health system as a whole – or that of IMSS affiliates (Interview, 05/11/99).

The economic team was aware that the private health sector was not prepared to absorb a sudden increase in health services demand, since with few exceptions

concentrated in the major urban centres, it continues to be a very desegregated market with very small unregulated providers scattered unevenly throughout the country (Interview, 05/11/99). Furthermore, given that the new Social Security Law had augmented the government's participation in the IMSS' funding, the group of businessmen who had been lobbying to have the opt-out policy implemented failed to present convincing evidence on the financial soundness of quota reimbursement – for both parties, the IMSS and employers<sup>35</sup>.

As a result, when the reform initiative to create and regulate the new HMOs was ready, the inter-agency group decided not to introduce it as a new law amendment to the Social Security Law, and instead sought to modify the General Law of Mutualist Insurance Companies and Institutions. The decree to amend the Law was presented to the Lower House on April 1999 and approved within a few days<sup>36</sup>. However, the initiative lay idle at the Senate, which did not put it up for debate for many months. Finally, with the political brokerage of the newly appointed Health Minister, it was approved in December 1999.

Policy makers involved in the reform initiative expected that with the regulation of the health business market, investors would be given certainty, and thus there would be a significant increase in private health infrastructure. This development would then contribute to solving what had been a *de facto* obstacle for the implementation of the IMSS' opt-out option. Also, a better developed and more regulated private health provision market would create incentives for current IMSS affiliates with purchasing capacity – and particularly their employers – to press for the implementation of the opt-out policy (Interview, 10/10/99).

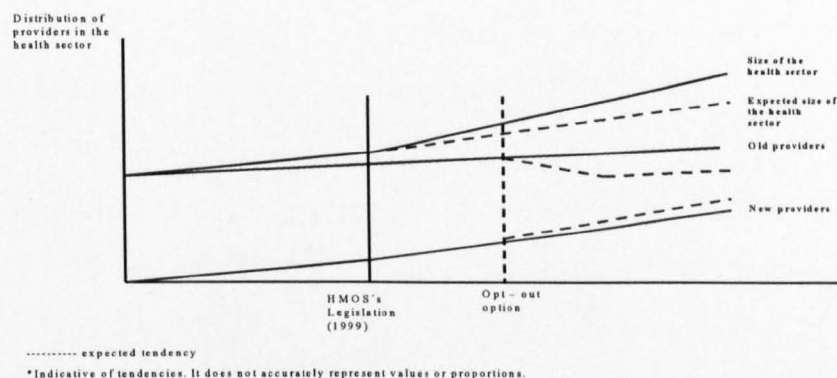
This long-term scenario would be conducive to the IMSS' downsizing and its effective reform<sup>37</sup>; and thus the health system would be significantly transformed in the direction envisioned by the economic team in the official health reform proposals – both sector-wide, and for the IMSS – without the need for direct political confrontation with the IMSS union. In other words, the economic team traded short-term comprehensive and state-directed change, for gradual and long-

run change brought about by market incentives. At the close of the present study's field work in December 1999, the creation of the new providers in the sector, the HMO's, and the IMSS integral reform were only in the making.

Figure (6.5) shows a simulation of tendencies of old providers (IMSS) and new providers (HMO's) in the health sector following the series of assumptions and decisions made by the economic team and its inter-agency group. The graph shows in solid lines the growth tendency of the IMSS – which increases with the expansion of formal employment – and the increase in number of HMO's and private providers (societal actors) as a result of a more predictable market due to the new regulation package. The dotted lines show the economic team's assumption that, with the IMSS' opt-out policy regulation sanctioned, a substitution effect would take place triggering the downsizing of IMSS and an increase of the HMO's share of the health sector.

In this scenario, a substantial reform of the sector would be obtained via an incremental and indirect strategy, based more on market tendencies and regulation than on direct short-term institutional change – and political confrontation with entrenched interest groups. With the postponement of the IMSS' opt-out policy, instead of this substitution effect what can be appreciated is the simultaneous presence of both old and new providers, increasing the total number of providers in the health sector. In this scenario, no substantive change is obtained beyond the emergence of the new providers, while social security health service provision remains firmly in the hands of the IMSS.

Figure 6.5: Old Providers/New Providers: Expected Changes in the Distribution of Health Sector Providers



As the Zedillo administration was coming to an end, the IMSS financial restructuring was well on its way. The significant increase in the government's quota participation – a result of the new 1995 Social Security Law – restored the IMSS' financial equilibrium. The IMSS change team – whose leader had become the Financial Division's Director – managed to complete the IMSS' financial re-engineering. The Family Health Insurance scheme has been operating since 1997 and has affiliated 300,000 families, but it still needed to expand more aggressively if it was to meet the government's stated goal of increasing access to the IMSS health services for all families with purchasing power who work in the informal economy. All the other policy changes in the IMSS' health reform – such as the integral model of health services delivery, AMDGs, family doctor eligibility, the use of performance incentives, and contracting out of services – were still in the pilot phase under the close scrutiny of the IMSS' union leaders. The opt-out and quota reimbursement policy has largely been left untouched.

## 6.7 Summary and Main Points

During the Zedillo administration (1994 – 2000), an ambitious health reform envisioning long-term policy change in the entire health sector was presented in the Health Reform Program. This reform included the transformation of the social

security health care services provided by the IMSS. However, due to the Institute's autonomous status, and the government's approach to social security reform as part of its economic policy – notably with the privatisation of the pensions fund in mind – the reform of the latter followed a policy process independent from that of the rest of the health sector.

The economic crisis and political de-legitimisation that took place at the outset of the Zedillo administration severely limited the possibilities of pursuing its reform agenda. The government concentrated on limiting and redressing the economic crisis damage, and revised all other reform initiatives. As a result, the pensions reform was given priority, but not so the health reform. This did not stop interagency competition – between the economic ministries and the IMSS – for the control of the health reform's formulation. This rivalry persisted during the entire reform process with each agency having a different team of policy-makers working on rival proposals within IMSS – CEDESS and the change team at the Financial Division.

The change team at the Financial Division was an extension of the government's economic team, and originally counted on the direct support of the Finance Minister. It was expected that this vertical network would empower the change team to isolate itself and its reform initiative from political pressures and from interest groups resisting policy change – notably the IMSS' union. However, with the resignation of the Finance Minister, the change team lost its vertical network and was thus forced to negotiate all elements of the reform initiative related to changes to the health services.

The IMSS union, the reform's most formidable veto group, was isolated from reform formulation, and had partial success in limiting the depth and scope of the reform initiative during legislation. But once the reform gravitated back to the IMSS for implementation, it resorted to its regained position of power to take control of the reform and stop policy changes that ran counter to its membership's interests – notably job profiles, wages and job security. Most importantly, it

presented effective opposition to the introduction of the opt-out option, which would have allowed for a public/private mix in health service provision for IMSS affiliates, a measure that would have brought about a significant transformation of the sector.

The reform's policy process took place in three major policy nodes. The main policy node was located within the Executive, during the period of policy formulation. All external actors, including the IMSS union, and to a great extent, the IMSS directorate, were excluded from this arena and precluded from participating in the decision-making process. The policy node located in the Executive – where factions from the economic team competed to influence it – was crucial to the reform of the IMSS' health component, since it was there that it was decided to approach it through regulation and administrative actions, rather than resorting to amendment of the Social Security Law.

The second policy node was located in Congress – specifically in the Lower House – during the process of approval of the new Law. In this case, PRI legislators vetoed the law amendment that sought to make a more systematic use of the opt-out option as a condition to vote in favour of the pensions system reform. Also, the IMSS union lobbied members of other political parties to vote against the social security law initiative, successfully reducing the number of votes in favour, but failing to derail it.

The third policy node was located within the IMSS during the implementation period. In this arena, the IMSS union constituted the principal veto group. The strength of the union was enough to control and in some cases block the change team's reform proposals, which, with no firm support or vertical networks – like the president or the economic team – needed to negotiate all its undertaking regarding policy change implementation. This affected the speed and scope of the reform that had been approved in the Legislature.

The government considered a last attempt at reforming the health sector using an

indirect strategy that would bring about change through new regulation and market incentives. It regulated the emerging HMO market and considered presenting this bill in Congress in tandem with the pending regulation package for the opt-out option. But once more, the latter was avoided and only the HMO regulation package was approved.

## Footnotes for Chapter 6

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<sup>1</sup> For details on the health care system and its relation to the political context, see González -Rossetti, 1994.

<sup>2</sup> The chart shows 10 million persons without access to health care. This population group is formed by the poor who are dispersed in the rural areas. Giving access to a basic health care package to this group was a central part of the government's health reform agenda. The analysis of this policy initiative goes beyond the scope of this thesis.

<sup>3</sup> The sole exception being the northern industrial states, where instead of building infrastructure, the IMSS allowed most companies in the region to procure health services for their work force in the private sector and reimbursed their quotas in what is called the opt-out option.

<sup>4</sup> Poder Ejecutivo Federal, *Plan Nacional de Desarrollo 1995-2000*, and *Programa de Reforma del Sector Salud 1995-2000*.

<sup>5</sup> *Programa de Reforma del Sector Salud 1995-2000*.

<sup>6</sup> *Programa de Reforma al Sector Salud 1995-2000*.

<sup>7</sup> Among the most relevant demographic changes are: rise of life expectancy, decrease in the birth rate, and increase in the population's average age. The epidemiological transition consists in: decrease in infectious illness and increase in chronic-degenerative sicknesses.

<sup>8</sup> IMSS, *Diagnostico*, March, 1995.

<sup>9</sup> *Diagnostico*.

<sup>10</sup> CEDESS, *Proyecto Águila*, December, 1994.

<sup>11</sup> Reformers also thought that the privatisation of the pensions system would help limit the political handling of the Institute's resources, since resources would cease to be deposited in a general fund, and instead would go to individual accounts.

<sup>12</sup> The contracting out of services was also considered a means to lower service provision costs. Administrative decentralisation and low and mid-level personnel layoffs were on the agenda as well.

<sup>13</sup> Other groups in society, particularly an academic group from the Xochimilco Autonomous University, have been studying the health care system for years, and publishing policy recommendations. However, these groups did not present formal policy documents with reform proposals as the other did; and did not have an important presence in the policy debate and the political struggle that evolved around the health reform process. For details on their policy positions, see Laurell, 1994.

<sup>14</sup> Also, the Presidency promoted competition between factions as a means to drive forward more "efficient" proposals, to limit the power of the different groups within the government and to consolidate its own power.

<sup>15</sup> Notably telecommunications.

<sup>16</sup> Following an unwritten agreement between both agencies, the assignment of this position had been in control of the Finance Ministry for many years.

<sup>17</sup> Gabriel Martínez, head of the Economic Deregulation Unit of SECOFI at the time, had contact with the work being carried out at CEDESS regarding the reform (Interview, 03/11/99).

<sup>18</sup> *Proyecto de Gran Visión* and *Proyecto Águila* were documents of restricted circulation.

<sup>19</sup> *Proyecto Águila*.

<sup>20</sup> Secretaría de Salud, *Cuadernos de Trabajo*, 1994.

<sup>21</sup> For instance, Funsalud's proposal was heavily criticised in an academic forum by the left-wing Xochimilco University group as a neo-liberal project that took away from the state its responsibility to guarantee free and universal access to health care for the entire population.

<sup>22</sup> See *Salud Para Todos los Mexicanos. Líneas Estratégicas para un Programa de Salud 1994-2000*, Grupo Asesor en Salud (SSA-SHCP-CEDESS-Funsalud-Grupo de Prospectiva), noviembre 23 de 1994.

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<sup>23</sup> IMSS, *Hacia el Fortalecimiento y Modernización de la Seguridad Social*, mid-1995.

<sup>24</sup> For instance, in relation to the pensions scheme, while the Finance Ministry economists were in favour of letting each worker choose his/her own pension fund, the Institute's representatives favoured the option of having either the union or the employer choose it for them (Madrid, 1998). Also, there were lengthy deliberations about the optimal share of employer and employee social security contributions and that of the government.

<sup>25</sup> This was particularly the case of the controversial opt-out option.

<sup>26</sup> Presentación al C. Presidente de la República, Ernesto Zedillo Ponce de León, de la propuesta Obrero-empresarial de Alianza para el Fortalecimiento y Modernización de la Seguridad Social, November 1995.

<sup>27</sup> These measures were intended to generate quasi-market mechanisms and competition as incentives for medical personnel to improve quality of services.

<sup>28</sup> In the speech following the presentations of business and labour representatives, President Zedillo committed his government to "respond" to their proposals.

<sup>29</sup> Audry voted against the first version of the reform proposal, but yielded in the end, changing his vote.

<sup>30</sup> Resistance to the reform was so strong, that even dropping the IMSS financial restructuring from the reform initiative was considered a measure to ensure approval of the pensions reform (Interview, 04/19/99).

<sup>31</sup> When a member of the union is assigned to a senior level position, he/she asks for a temporary leave of absence for the duration of this assignment. This means that formally, senior level positions are not unionised, but informally, the union retains control over them.

<sup>32</sup> CEDESS, which had been created to support the IMSS Directorate in this endeavour, had been marginalized and nearly dismantled, with its activities reduced to the undertaking of some policy studies.

<sup>33</sup> Since it joined the independent labour movement, the IMSS' union has made a veiled threat to juggle alliances between the PRI and the PRD, a matter of concern for the former – and of interest for the latter – given the size and level of organisation of its membership. The union's leaders in the past have had close relatives join key positions in guerrilla movements such as the National Liberation Front and the EZLN in Chiapas.

<sup>34</sup> Since investors in the HMO market are interested in catering to IMSS affiliates who would look for services in the private sector if the opt-out option is applied.

<sup>35</sup> Contradictory explanations in interviews with both state and society actors as to why the implementation of the opt-out option did not go ahead, showed how contentious the issue remained. While some contended that the regulatory body needed to implement this policy was ready, but there was no political will to put it into practice (Interview, 05/05/99), others contended that the technical complexity behind it was such that the regulatory body was yet to be made operational (Interview 05/05/99b). Also, since the new Social Security Law significantly diminished the employer-employee quota share by augmenting that of the government, business' urgency to press for the implementation of the opt-out options dwindled. The reimbursement of the lower quota share to business in the case that the opt-out option were applied, made paying for an equivalent package of health services for employees in the private sector financially unfeasible.

<sup>36</sup> The goals of the regulation package for the emerging HMO market were: to promote market development, give certainty for investment and guide and protect the consumer. "Exposición de motivos a la "Iniciativa de Reformas a La Ley General de Instituciones y Sociedades Mutualistas de Seguros".

<sup>37</sup> The outcome of the implementation of the opt-out option remains unclear, since the complex factors around employers' and employees' choice between staying in the IMSS or choosing an HMO service makes it unpredictable.



## **Chapter 7. Change Teams and Their Strategy Choice**

### **7.1 Introduction**

In the competition for the control of the social security reform project between the economic team and the IMSS Directorate, both tried to form a change team and empower it as a strategy to gain leverage over the definition of the reform. Reflecting the institutional rivalry between the economic team and the IMSS, these two groups did not have incentives to join efforts, and instead competed for influence over the reform process, even though both were located within the IMSS. From the outset, both teams had different policy agendas and these were reflected in their differing reform proposals.

This chapter analyses the characteristics of the two groups of reformers within the IMSS that were intended to lead the reform, their political manoeuvring and their choice of strategies as they prepared alternative reform projects. It also examines the Executive's interagency groups and their decision-making process on the reform's content and choice of strategies. Particular emphasis is put on explaining why all these groups of reformers – both within the IMSS and within the Executive – opted for eschewing short-term in-depth change – requiring direct confrontation with entrenched interests – and favoured long-term incremental policy change brought about by market forces and competition assumed to be triggered by the creation of societal actors in the health sector (the HMO's).

### **7.2 Two Attempts at Forming a Change Team**

#### **7.2.1 The IMSS Change Team**

Economic reform in Mexico was promoted during the eighties and nineties by a small group of technocrats whose careers were based at the financial and economic government agencies – defined here as core ministries. This economic team<sup>1</sup> had ideological and programmatic cohesiveness, and its members shared a high level of technical training and a commitment to economic liberalism. However, given that Mexico's informal rules for designating the presidential

candidate (Centeno: 1994) for the incoming administration made many of the team members potential candidates<sup>2</sup>, their cohesiveness in ideology and policy content was hampered by their political manoeuvring seeking to better position themselves.

Thus, at least two factions – or *camarillas* – could be distinguished within the economic team, which competed for political power and the control of strategic projects that were part of the president's policy agenda, and by the number and nature of the government positions to which each faction could assign its members (Waterbury, 1992). These dynamics left their imprint on the social security reform process from its outset, since the economic team's factions competed for its control.

The first change team that was assigned to work on the social security reform was formed under the auspices of the economic team's faction led by then Finance Minister Pedro Aspe during the early nineties. With the economic reforms – or first generation reforms – on their way towards consolidation, Minister Aspe had turned the agency's efforts towards studying options for the reform of the social sector – or second generation reforms. The rationale behind this agenda was to avoid the impending negative impact that the inefficient and financially unbalanced social sector could have on public finances. Thus, in order to promote the study of policy options and develop a project to privatise the retirement pensions system, Finance Minister Aspe formed a group of very young and highly trained economists, mathematicians, and actuaries, who shared a neo-liberal ideology and had as their main goal the reform of the state (Waterbury, 1992; Centeno, 1994; Dominguez, 1997). Team members were isolated from the rest of the state bureaucracy, and from other interest groups, so as to avoid external pressure on the project's formulation.

Aspe and the social security change team had been involved in the economic reforms of the eighties and nineties, and continued to work under the assumption that all sectors – both in the economic sphere and in the social sphere – could be reformed by following a similar strategy: modifying rules and incentives to trigger

policy change by having actors in the sector being reformed respond to the new rules of the game. Thus, their reform proposal resorted to policy strategies such as privatisation, market competition, and eligibility of service provider. At this point, this team did not incorporate the reform of the IMSS' health care services as a component of their reform proposal, and focused exclusively on its pensions component, because it had a direct impact on the governments fiscal balance.

A political struggle between the two rival factions within the economic team led to a take-over of the pensions project by the faction led by Jose M. Cordoba, the President's Chief of Staff. Thus the pensions team backed by Minister Aspe was forced to abandon the project in mid-1993, and Guillermo Ortiz, the Finance Deputy Minister – who belonged to Cordoba's faction – assumed control of the project, designating his chief of staff as project leader<sup>3</sup>.

From mid-1993 through 1994, the new pensions group – still at the Finance Ministry, but with the backing of the Office of the Presidency – worked to develop a social security reform proposal in close co-operation with Jaime Serra Puche, the Commerce Minister – who belonged to the same faction – and his collaborators. The new pensions team followed the same assumptions and policy choices as the previous group. This team also failed to include the reform of the IMSS' health component, but did include the financial re-engineering of the Institute.

As the change of administration approached and in preparation for implementing the pensions reform, Minister Serra Puche had Gabriel Martinez<sup>4</sup>, one of his economic advisors and then head of the deregulation unit, appointed to a position in the IMSS' Finance Division, where, working as an extension of the economic team, he was to form and lead a change team of very young professionals with training in economics and accounting and no previous experience in pensions or health, in charge of pursuing the IMSS' reform.

The appointment of Martinez to head the IMSS reform within the IMSS points to the economic team's reliance on changes in regulation as a strategy choice. In his position as head of the Deregulation Unit in the Ministry of Commerce, he helped

develop the proposal to reform the structure of the pensions system and IMSS' finances, and had participated in all stages of the reform process – if tangentially at the beginning – ever since Cordoba's faction had taken control of the Social Security reform project within the economic team.

Soon after taking office in late 1994, President Zedillo appointed Serra Puche as his Finance Minister. This endowed the new IMSS change team under Martinez' leadership with a crucial vertical network, empowering it to pursue its reform agenda. The change team faced resistance from the IMSS bureaucracy and from its Directorate, which perceived it as foreign to the Institute and an intrusion from the economic team in the Finance and Commerce Ministries (Interview, 04/04/97). And indeed, this change team made little effort to establish a network within the IMSS<sup>5</sup>. Instead, it concentrated on moving as swiftly as possible with the financial re-engineering of IMSS insurance funds and the other components of IMSS reform, and continued to work very closely with their peers in the Finance and Commerce Ministries – its horizontal network<sup>6</sup>.

The IMSS change team's reform agenda followed the same assumptions as those of the two pensions teams in the economic team: through financial adjustments, it intended to modify the rules and incentives that regulated the IMSS' internal proceedings in the administration of funds and the provision of services. These changes were expected to lead to more transparent, equitable and efficient processes without the need to impose changes on the IMSS bureaucracy – and thus avoiding directly confronting it.

With the economic crisis of December 1994 and the resignation of Jaime Serra as Finance Minister, the IMSS change team lost its single most important vertical network of support. This forced the change team to slow down and reduce its reform agenda to remedial policies aimed at re-engineering the defaulting IMSS finances. With very few exceptions in which the change team was able to maintain its policy agenda isolated by its high degree of technicalities, the change team was forced to negotiate all items of policy change with the IMSS union, a formidable veto group. Simultaneously, and also as a result of the economic crisis, the

pensions reform became a priority on the government's agenda, and thus the economic change team kept the matter within its realm and away from the IMSS. However, within this narrow space for manoeuvre, it still managed to continue to operate with the support of the horizontal networks it counted on – notably with Finance Ministry officials who were Martinez' former peers and also members of the economic team. This allowed it to focus on the parts of its reform agenda requiring the cooperation of the Ministry of Finance, such as significant aspects of the IMSS financial reengineering program, and securing loans to ensure the availability of financial resources required to further policy change<sup>7</sup>.

### **7.2.2 The *Centro de Desarrollo Estrategico para la Seguridad Social* (CEDESS)**

Parallel to the economic team's initiative in social security reform within the Executive – and to the factional competition for the social security project – IMSS Director Genaro Borrego founded the *Centro de Desarrollo Estrategico para la Seguridad Social* (CEDESS), as part of its efforts to establish the conditions for the project to gravitate closer to the IMSS' area of influence. In creating CEDESS, Borrego attempted to create a technocratic change team similar in nature and modus operandi to those used by the economic team as a means not only to insulate policy decision-making from the IMSS bureaucracy (Interview, 03/22/99)<sup>8</sup>, but also to reach out to the economic team and establish closer ties of co-operation. The CEDESS team was thus made up of apolitical technicians with as possibly similar backgrounds and policy experience as those of the technocrats in the Finance Ministry. Economists, mathematicians and actuaries were hired to develop a technically sophisticated reform proposal to which the technocrats of the economic and financial agencies of the government could relate<sup>9</sup>.

The task assigned to the CEDESS team was to develop an integral social security reform proposal along the lines of the economic team's discussions. But, as the imprint of the IMSS Directorate, it should go beyond the reform of the IMSS' pensions scheme, and include a plan to reorganise the provision of health services.

While CEDESS did resemble a change team since it operated separately from the IMSS bureaucracy, with policy-makers foreign to the Institute, and isolated from possible pressure from interest groups within and outside the agency, the IMSS Directorate was not successful in transforming it from a think tank into a change team. The political leverage of the IMSS as an agency – when compared to that of the economic team in the core ministries – was not sufficient to endow CEDESS with a vertical network of support and thus empower it to lead the reform. In other words, in spite of counting on Borrego's political backing, CEDESS was not able to compete on equal terms with the other teams working on alternative reform projects within the Executive and within the IMSS proper.

This resulted in CEDESS playing a subsidiary role in support of the economic team's decision-making within the Executive. Thus, in what pertained to the pensions component of its reform proposal, CEDESS members – who were close to the economic team – developed policy initiatives along the lines of those developed within the Executive, ones that questioned the role of the state as the main provider of social services, and proposed market mechanisms and an enhanced role for the private sector to manage the pensions funds. In contrast with its pensions reform project, CEDESS' proposal for the health component did not question the central role of the state as the main provider of health services, but simply put forward a series of measures to increase the quality and efficiency of service provision through quasi- market mechanisms such as doctor eligibility, contracting-out and some competition generated by the introduction of a public/private mix through the opt-out option<sup>10</sup>.

### **7.3 Characteristics of the IMSS Change Team and CEDESS**

The IMSS change team was a cohesive group with similar training – mostly in economics – which shared a pro-market ideology, and had a single reform project: the transformation – and reduction – of the role of the state, in this case in social service delivery. In contrast, the CEDESS was not cohesive and its members, who had diverse training – including actuaries, economists and doctors – represented different ideological positions, which spanned from an enhanced role for the market to preserving the role of the state in social service delivery. As a result,

CEDESS' members did not share a single reform project, but instead brought policy proposals that reflected different visions of the role the IMSS should play.

The IMSS change team members had made their careers through the bureaucratic ranks of government, based entirely on the support of peers within the state. Thus it had no experience of seeking consensus-building beyond internal bureaucratic manoeuvring. CEDESS shared this technocratic trait, in that its members had no political manoeuvring experience, either; but it did not attempt to lead policy change. Instead, it acted as a group of technical officials assigned to support the IMSS Directorate's decision-making and, tangentially, its political manoeuvring.

#### **7.4 Political Manoeuvring of the IMSS Change Team and CEDESS**

Team members of the IMSS and CEDESS did not have any personal political support or power base outside the Executive, therefore the political feasibility of their reform agenda and of their leading position in the reform process depended exclusively on the support of the president and the government's economic team (vertical networks). This fact shielded them from political pressure from outside the Executive, but not from other government factions involved in the process. Therefore, not having a social mandate or a particular coalition of support made them entirely dependent on changes in the economic team's – or the president's – policy priorities.

##### **7.4.1 Vertical Networks**

When it was formed and first assigned the reform of the IMSS' health component, the IMSS change team counted on the direct support of the Finance Minister, who was thus its highest vertical network, capable of empowering the change team to lead the reform. However, with the resignation of the Finance Minister, it lost this political support – which was not replaced by a similar vertical network – and thus also its empowerment. The CEDESS' highest vertical network stemmed from the IMSS' Director, which proved insufficient to empower CEDESS to lead the reform, particularly in a context where the IMSS rivalled other more powerful agencies, such as the core economic ministries for control over the reform.

### **7.4.2 Horizontal Networks**

The IMSS change team had strong horizontal networks with former colleagues who had participated in the economic reforms during the Salinas administration at the core ministries – notably Finance and Commerce – as well as a few networks in the Presidency's Office and the Ministry of Health. Once the IMSS change team lost its vertical network, it was these horizontal networks which granted it a minimum space for manoeuvre to be able to continue with some elements of its reform agenda – particularly those related to the financial aspect of the reform, which had to be done in co-operation with the Ministry of Finance.

While some CEDESS members also counted on horizontal networks with the Finance and Commerce ministries – notably those in charge of the pensions component of the reform – their support did not become extensive to all the team's members given their lack of cohesiveness and the fact that they did not operate as a single body. The economic team recognised but a few of CEDESS members as equal partners, and did not perceive it as a change team or as a change team capable of policy decision-making and of negotiating the reform. Instead, through the few horizontal networks, it reached some temporary level of co-operation by approaching it as a think tank and using its input to support decision-making.

### **7.4.3 State-Society Networks**

Both teams developed very few state-society networks and instead resorted to sporadic contacts. Given the lack of leverage of both groups, they were subordinated to the IMSS Directorate's control of relations with societal actors.



## 7.5 Choice of Strategies of the IMSS Change Team and CEDESS

Changes to the reform's content carried out as a strategy to enhance the reform's chances of being pursued, went beyond the decision-making power of both the IMSS change team and CEDESS, and remained firmly in the hands of the interagency groups within the Executive. Such was the case of the **speed and scope** of policy change the reform should entail, and the **choice of legislation** – i.e. the final content of the reform initiative presented to Congress, which reflected decisions as to whether to induce change through legislation or regulation, for instance.

The IMSS change team did not participate in **brokerage in Congress**. This was left in the hands of the IMSS Directorate, which relied on CEDESS for support – such as the preparation of policy briefings and presentations in Congress – but not for decision-making around political strategy. The role of both groups in **policy dialogue** was also marginal, since neither was assigned the negotiation of the reform. In the case of the IMSS change team, it resorted to an insulation strategy at the outset, but when it lost its vertical network, it was forced to establish policy dialogue with interest groups opposing change – notably the IMSS bureaucracy through its union. CEDESS organised a series of forums on social security with the participation of foreign specialists, but this was part of the IMSS Directorate's overall strategy to win public opinion, and not an independent action from CEDESS proper.

With regard to **transition strategies**, while CEDESS did not have any participation at all, it could be argued that the IMSS change team independently decided to move ahead quietly but swiftly with the IMSS' financial re-engineering with two goals in mind: First, to bring about as much change as possible to avoid having it reverted once it was substituted in the IMSS' Financial Division. Second, to put as many “locks” on the system to make it transparent and avoid political use of funds and corruption. The IMSS change team also secured multilateral loans to ensure funds to cover the reform's transitional costs and therefore raise the chances of its continuing in the medium to long run.

The IMSS change team and CEDESS held different views on strategies to **induce change**, particularly as regards the reform's health component. The IMSS change team shared the economic team's view that changes in health service provision could be induced in the long run and indirectly through market forces, while CEDESS proposed the direct implementation of changes in the short term. However, none had the power to take the ultimate decision, which was yet again in the hands of the interagency groups. These favoured the pro-market/indirect option, but this coincidence with the IMSS change team stems from the fact that it shared a common view about the role of the state and the market with the economic team, rather than as a result of its negotiation. Once the IMSS Directorate lost the bid for control of the reform initiative – for which it had chosen the health reform as a trade mark – the direct implementation of policy change in the IMSS health services as suggested by CEDESS was reduced to a minimum, with only a few pilot projects taking place.

### **7.6 The Executive's Interagency Groups**

The economic team within the Executive did not delegate final decisions on policy content either to the IMSS change team, or to CEDESS. Instead, it put together one interagency group in charge of looking into the social security reform – with particular emphasis on the pensions component – and later on, another interagency group in charge of looking into policy changes to the health sector – where the reform of the IMSS health services was considered once more. While these groups within the Executive resembled change teams to a large extent, they were not empowered to broker the reform initiatives, nor to implement them. Instead, in a sort of “division of labour”, the IMSS' Directorate was put in charge of brokering the reform – with the support of CEDESS – and the IMSS change team of implementing it.

### 7.6.1 The Social Security Interagency Group

In view of the 1994 economic crisis, President Zedillo and his economic team decided to push forward the pensions reform proposal that had been developed during the previous administration. An interagency group was designated by the economic cabinet to adjust this proposal within the Executive. The interagency group was made up of officials from the Finance Ministry<sup>11</sup> and the pensions regulation agency CONSAR<sup>12</sup>, as well as officials from the IMSS, including the IMSS change team's leader, Gabriel Martinez. There were also representatives of the Ministries of Labour and Health<sup>13</sup>, and from the Office of the Presidency. The team was assigned the development of the final pensions reform proposal. This interagency group worked in isolation and did not open the discussions on the reform's content to other arenas outside the Executive. Although the interagency team took into consideration the proposals developed at CEDESS, they did not grant it access to the decision-making process.

Formally, an interagency group's function is to represent the various government agencies relevant to a specific arena of policy-making and to create an arena for representation and negotiation. However, because the majority of this group's members had been part of the economic team leading reforms in the previous administration, they shared a common policy agenda that went beyond that of their respective agencies. Therefore, with the exception of the Labour Ministry representatives, they put aside their institutional position and worked as a task force. In that manner, this group operated in resemblance to a change team, since it worked as a cohesive group, with a common agenda based around unified ideological and programmatic principles. This was further reinforced by the Presidency's direct participation and arbitration of policy discussions.

In accordance with the president's priorities, the team decided to push forward the restructuring of the pensions system and the financial re-engineering of the IMSS, and postpone the health component reform. The interagency team briefly considered the restructuring of the IMSS health component as it was formulating the final proposal of the pensions reform. However, it was this team which decided

to postpone it in order to ensure the political feasibility of the new pensions scheme and its approval in Congress.

### **7.6.2 The Health Interagency Group**

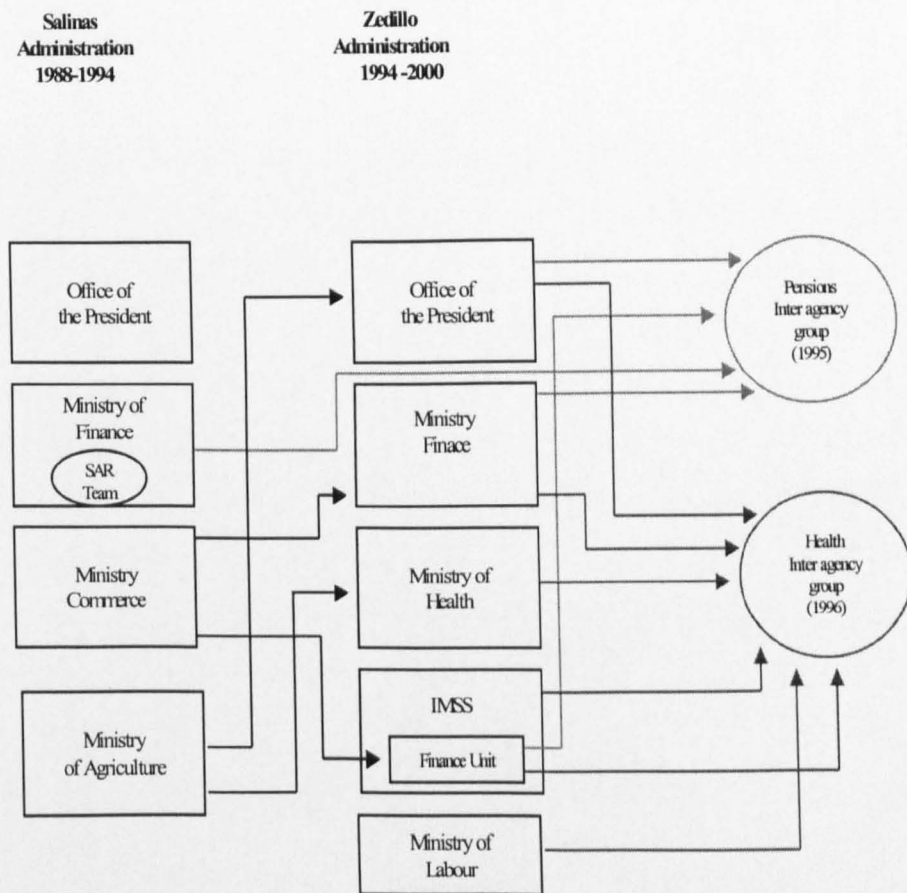
After the new Social Security Law was approved and the pensions interagency group had been dispersed, another interagency group was created within the Executive, now with the task of formulating the regulation of the emerging HMO market in the private health sector. Their initial objective was to simultaneously regulate the emerging HMO market along with the IMSS' opt-out policy, but while officials in the economic team considered it a priority to regulate the emerging HMO market – in order to give the new industry economic certainty and protect the users – the same was not the case for the regulation of the IMSS' opt-out policy.

The health interagency group presented most of the characteristics of the social security interagency group. It was made up of a reduced number of policy-makers with high technical training – most of them were economists and lawyers – who were assigned the formulation of a specific aspect of the health reform. It was also an ideologically and programmatically cohesive group isolated from external interest group pressure. Also it was not assigned the political manoeuvring to broker the bill<sup>14</sup>.

Although this group had the formal purpose of representing the agencies involved in the reform process, most of its members subordinated this function to that of involving themselves as technical apolitical policy-makers in the formulation of the reform proposal. Among the team's members, only the IMSS officials used the interagency group as a forum of agency representation to try to influence the decision-making process<sup>15</sup>. However, the direct involvement of the president's staff maintained the group's cohesiveness around the predominant reform objective, and soon the IMSS officials were partially isolated.

Figure (7.1) presents a diagram showing the positions the members of the pensions and health interagency groups had during the Salinas and the Zedillo administrations. Note that the majority stems from the core economic agencies in both administrations.

Figure 7.1: The Executive's Interagency Groups



The team approached the reform as a regulation problem. This meant setting up the rules to create and regulate societal actors in the health sector, such as Health Management Organisations (HMO's) to provide private services to middle income groups through individual health insurance plans. The regulation of the emerging HMO's market was also intended to boost private investment in health infrastructure in the short run. And in the long run, through the simultaneous regulation of the IMSS opt-out policy, to create the market forces to induce the

transformation of the health sector's old providers – such as the IMSS – through market competition.

However, when the team was made aware of the IMSS' union's mounting political pressure against the implementation of the opt-out option<sup>16</sup> it concluded that the intention to regulate both issues at the same time could affect the political feasibility of having the HMO market regulation approved in Congress. Thus, given that the opt-out policy was not part of the government's policy agenda, and its benefits remained unclear in the short run, it was postponed once again.

After the initiative was presented by the Executive in Congress, the health care interagency group was dismantled and the initiative was “frozen” by Congress. Only a few mid-level officials from the Finance Ministry continued to broker the initiative within the Executive, in order to jump-start its efforts to obtain congressional approval. However, it was not until the new Health Minister, Jose Antonio González Fernández –whose profile was similar to that of IMSS Director Borrego, inasmuch as he had pursued a political career within the ranks of the PRI, but interacted with the technocratic group in power–, took on the initiative as part of his policy agenda and personally lobbied it before Congress and the PRI. He finally managed to have it approved towards the end of 1999.

### **7.7 The Executive's Interagency Groups' Choice of Strategies**

Given that the Executive remained in control of the government's social security initiative instead of delegating it to either the IMSS change team or CEDESS, it was the interagency groups which made decisions on the reform's final policy content, and, along with it, the policy choices. In these circumstances, the interagency groups made a series of strategy choices aimed at enhancing the political feasibility of those policy issues that had priority on their reform agenda – the pensions reform and the creation of new private health services providers, respectively. Their choice of strategies responded to the opportunities and limitations the institutional context and the nature of the reform posed to them. Some strategies entailed defining the degree of participation in policy decision-

making, whereas others entailed modifications to the reform's policy content in order to ensure its political feasibility.

In regard to the pensions reform, the social security pensions interagency group sought to trigger in-depth short-term comprehensive change through new legislation, along the lines of economic reform efforts pursued by the economic team in the past. In stark contrast to these groups' choice of policies to pursue policy change in the pensions scheme, this groups' choice of **speed and scope of policy change** for the health reform was to avoid in-depth short-term changes, and instead to rely on incremental changes in the short run. In a follow-up of the Executive's decision to prioritise pensions at the expense of health, the health interagency group also only attempted to trigger incremental change.

Following this logic, the social security interagency group considered only briefly the possibility of including law amendments geared to reforming the IMSS' health services in the social security reform initiative to be presented in Congress – on the grounds that these services were an integral part of the IMSS. Instead its **choice of legislation** was to resort to internal administrative acts within the IMSS. It did so in order to avoid jeopardising the passing of the new law reforming the pensions scheme; but this decision was also based on the fact that the original social security law already endorsed the IMSS' opt-out policy, which could be systematically implemented by establishing its regulation through an administrative act. When the health interagency group considered the reform of the IMSS health services anew – this time on the grounds that the group was exploring policy changes in the health sector – this fact also influenced its choice of legislation. Again, changes in legislation to bring about policy change in IMSS services were discarded as politically contentious; and instead, the option of relying on the IMSS' internal administrative acts was endorsed.

### **7.7.1 Inducing Change**

This choice of strategies also ran in tandem with the interagency groups' choice of mechanisms to induce change, one that was based on the groups' assumptions – which in turn were based on their experience with first generation reforms – and the ideological stand of their members. The mechanisms both groups chose were changes in rules and regulations as a means to bring about policy change, and a reliance on market forces. Thus, in the case of health reform, both groups chose to avoid imposing change, which would have required a direct confrontation with entrenched interests – thus putting in jeopardy both groups' reform priorities. Instead, both groups chose to induce change indirectly through the concurrence of two factors: First, the issuing of IMSS administrative decrees regulating the systematic implementation of the opt-out policy – thus allowing social security affiliates to choose their own health service plan. And second, generating market competition by putting in place the incentives for the creation of HMO's these affiliates could turn to as an alternative service.

In other words, with the simultaneous regulation of the IMSS' opt-out policy, the team expected to promote a shift of IMSS affiliates to the new HMO's. The introduction of competition by creating new health service providers and allowing IMSS affiliates to switch to them, was expected to trigger improvements in health care quality. As they gained economic strength and political weight, HMO's would also represent a new base of support to confront the old agency's bureaucracy – and particularly its union. However, neither of these two factors were under the control of the interagency groups – the issuing of these administrative decrees was in the hands of IMSS authorities, and competition depended on market incentives and timing.

### **7.7.2 Policy Dialogue**

The interagency groups worked in isolation to formulate the reform proposals. Their capacity to insulate policy formulation from other actors depended on two elements. First, the political backing of the president, and second the institutional



context in which they were immersed. In other words, the formal and informal rules of policy negotiation that empowered the President to conduct reform formulation within the Executive away from public scrutiny and from other arenas of interest representation – Congress notwithstanding. Only the requirements of this institutional context, or the need to rely on the IMSS’ bureaucracy for the implementation of certain aspects of the reforms forced the interagency groups to “open up” and negotiate with groups outside the Executive. Such was the case of reform legislation, and thereafter, the implementation of some of its components in the IMSS – notably its financial re-engineering; and on these two occasions it did so indirectly, by relying first on the IMSS Directorate, and later on the IMSS change team.

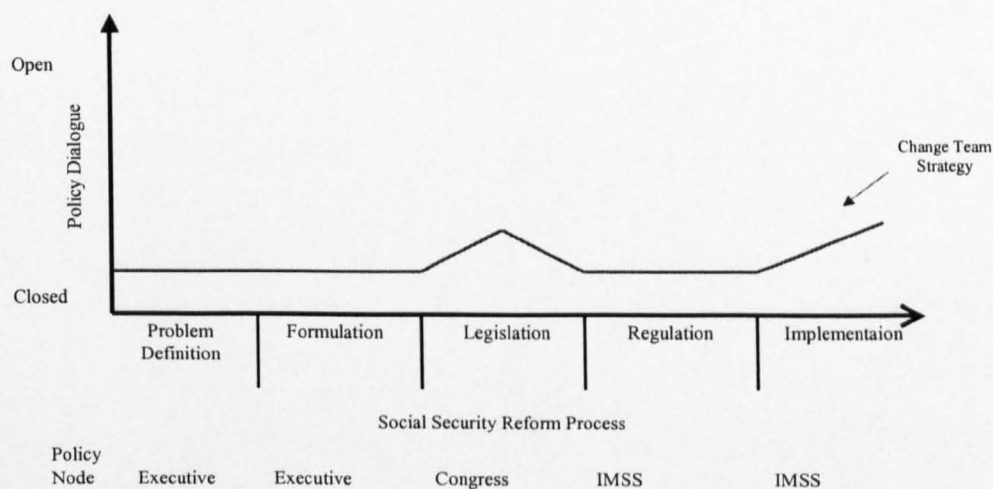
During the legislation stage the interagency groups chose to rely on the old PRI corporatist structure to secure support for the pensions reform, control resistance from powerful interest groups – particularly the IMSS union – and secure the PRI’s vote in Congress. To that end, it assigned the **brokerage** to IMSS Director Genaro Borrego, who had a political profile – with a career based in the PRI ranks and elected positions – and therefore was able to establish policy dialogue with the party’s corporate organisations – particularly labour – and peak associations.

During the implementation stage, the interagency groups assigned the IMSS change team to bring about policy change from within the IMSS. Following the same strategy choice of the interagency groups – since it worked as an extension of the economic team – the IMSS change team also tried to insulate reform implementation from interest groups resisting change – particularly the IMSS union. But its lack of leverage within the IMSS bureaucracy greatly reduced its control over policy change, and forced it to negotiate and seek consensus with those groups resisting change.

Figure (7.2) presents a diagram with the change team’s choice of strategy over policy dialogue. The horizontal axis presents the different stages of the reform process. The vertical axis represent the choice of policy dialogue from closed or non existent (insulation), to open or inviting participation (consensus building).

The line presents the team's choice at each stage. The closer the line is to the horizontal axis, the less policy dialogue and thus the more insulated the change team. The diagram shows that the change team chose a strategy other than insulation only during reform legislation. That is, at the stage of the reform process in which the institutional context forced the team to abandon the insulation strategy and engage in policy dialogue to broker the reform.

Figure 7.2: Change Team Strategy Choice on Policy Dialogue



## 7.8 Summary and Main Points

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

During the early nineties, a group of these technocrats from the Ministry of Finance and the Central Bank, led by Pedro Aspe, the Finance Minister, developed

a project to privatise the retirement pensions system, which directly involved the IMSS. This group was forced to abandon the project in mid-1993 following a take-over by a rival *camarilla* led by the Presidency's Office along with the Commerce Ministry. From mid- 1993 through 1994, this technocratic faction worked to develop a proposal for the reform of the pensions system.

The economic team's strategy to pursue the pensions reform followed the same pattern that had been used during the first generation reforms. A small change team of highly technical policy-makers, foreign in training and professional experience to the IMSS, was placed in formal positions within it, and its coordination was assigned to Gabriel Martinez, a junior member of the Executive's economic team. In this way, the team in charge of implementing the IMSS' financial re-engineering was an extension of the economic team, linked by a vertical network that consisted of the direct support of Jaime Serra Puche, who was named Finance Minister at the outset of the Zedillo administration. However, with the resignation of Serra Puche, this vertical link was to be broken and the IMSS change team was left without the political support of the core ministries. This event considerably narrowed its scope of action, slowing the pace of the IMSS reform. This fact was further aggravated by President Zedillo's decision to halt his support for any policy reform that was not directly related to solving the economic crisis.

The IMSS Directorate, for its part, also attempted to create a change team similar in nature and modus operandi to those used by the economic team in the core ministries, by forming the Strategic Development Centre for Social Security (CEDESS) in mid-1993. The creation of CEDESS responded to Borrego's political strategy of establishing working links with the economic team, through a decision-making space outside the realm of the IMSS bureaucracy and its interest groups – notably the IMSS union. The IMSS Director shared the perception that the creation of a technocratic change team made up of non-IMSS policy-makers was an effective strategy to bring about policy change within a setting of resistance.

However, he was not successful in transforming CEDESS from a think-tank into a change team. The CEDESS group lacked a series of traits that are indispensable for the formation of a change team, such as ideological cohesiveness and a common reform agenda. But most significantly, it lacked vertical networks of support stemming from the core ministries. The economic team did not recognise the group in CEDESS as a technocratic group of policy-makers with the credentials to become a partner in the IMSS reform. Furthermore, the CEDESS group did not have the horizontal networks with other technocratic policy-makers in other ministries, as the IMSS change team did – notably, with the Finance Ministry.

The Executive maintained control over the social security reform and put particular emphasis on its pensions component. Instead of delegating decision-making to either the IMSS change team or CEDESS, it created ad hoc interagency groups within the Executive under the leadership of the economic team, to study the reform proposals presented by CEDESS and the IMSS change team, and decide on the reform's final policy content. These interagency groups formally served as an arena for the representation of the core ministries and other government agencies involved, but this was not their main role. The interagency groups' members were like-minded policy-makers who shared a common ideology and similar views on the reform agenda. Therefore, they worked more as a task force than a negotiation table, since there was little need to seek consensus, but instead members departed from a platform of consensus and concentrated on reform formulation.

These groups prioritised the use of changes in rules and regulation as a means to bring about policy change. This was aimed at bringing immediate change to the pensions component, but in the case of the health component, it implied inducing change indirectly, through market forces that would only have an impact in the long run.

The IMSS change team prioritised the elements of the reform that were related to the financial re-engineering of the Institute, while the CEDESS used as its

trademark a more integral approach to the IMSS' reform, which included the transformation of IMSS health service provision. However, in spite of CEDESS' efforts to introduce short-term direct changes to the IMSS' health services along the pensions reform, all items pointing in that direction were removed by the interagency groups before the Executive presented the reform initiative to Congress on the grounds that they faced serious resistance from politically powerful interest groups – such as the IMSS union – and could therefore jeopardise the pensions reform.

The Executive's faltering support for the inclusion of the health component in the social security reform initiative and its willingness to maintain control over the social security reform process – through ad hoc interagency groups – hampered both teams' potential to secure powerful vertical networks to help them lead the reform. As a result, a sort of “division of labour” was established in which the Executive's interagency groups would have the last word on reform formulation, the IMSS change team was assigned the formulation of the policy's technical details and regulation, and CEDESS was relegated to backing the IMSS Directorate in the efforts to broker the reform with groups in Congress and in society.

The analysis of the two groups within the IMSS which attempted to take control of the reform process – the IMSS change team and CEDESS – and the two interagency groups that were assigned the reform's formulation by the Executive – the pensions interagency group and the health interagency group – shows that the technocratic characteristics of the last two administrations led the Executive to use the same strategy it used to pursue economic reforms – first generation reforms. It opted for a strategy of insulation whereby the participation of societal groups and governmental agencies was restricted and entirely controlled by the core ministries, which, regardless of the policy issue, determined both the degree of participation and the composition of the group that was assigned the different tasks related to the reform process. Also, due to the Executive's concentration of power, and the secondary role played by other arenas, Congress notwithstanding, these

four groups found an ample space for policy definition only limited by the economic team's support and interest in the issue.

## Footnotes for Chapter 7

<sup>1</sup>For details on Mexico's technocracy, the economic team, and its relation to the political context, see Waterbury, 1989 and 1992; Haggard and Kaufman, 1992 and 1995; Kahler, 1992; Grindle 1994 and 1996.

<sup>2</sup>By which for the last 70 years the president in office names his successor from a member of the Cabinet at his discretion.

<sup>3</sup>During interviews two alternative explanations for this take-over were put forth. One pointed to an effort to establish a closer link between the pensions reform project and the president, thus helping to insulate it from the internal political struggle surrounding the presidential succession (Interview, 08/04/99). The other pointed to an effort to establish a clearer line of control between the president and the reform's content (Interview, 08/04/99). Yet it could have been possible that the economic team's factional competition was the main cause behind it with the new faction taking advantage of a window of opportunity opened by pressure from government factions unsatisfied with the partial results the Finance Ministry had obtained during its first attempt at pensions reform (Interview, 04/16/99).

<sup>4</sup>Gabriel Martínez had a PhD in economics from Chicago University. Since 1993, and still working at the Commerce Ministry, he was commissioned to interact and co-operate with the CEDESS group, a think-tank for the IMSS directorate.

<sup>5</sup>The IMSS change team and Martínez worked in isolation with the sole exception of Eduardo Gonzalez Pier, a economist with a PhD in economics who was Martínez' second on board and was in charge of brokering the reform with other groups within the IMSS and societal actors interested in the reform.

<sup>6</sup>Notably with Santiago Levy, the Finance Deputy Minister in charge of social sector budget allocations.

<sup>7</sup>See Appendix 2.

<sup>8</sup>The Centre was perceived by its members and by the IMSS Directorate as a space away from the pressures of bureaucracy where researchers 'dared to think' (Interview, 02/25/99).

<sup>9</sup>The pensions group was headed by Enrique Dávila, an economics professor with a PhD in economic history from the University of Barcelona with a pro-market approach, who had been advisor to the now Finance Deputy Minister Santiago Levy, when he headed the Economic Deregulation Unit of the Commerce Ministry (SECOFI) in the previous administration. The health team was headed by Dr. Mario Villafaña, a doctor who stemmed from the ranks of the IMSS, where he had spent all his career practising in the IMSS' health services. He did not question the state's role in service provision, and instead looked to ameliorate the quality and efficiency of IMSS health services through this reform initiative. The labour risks team was headed by Jorge Rendón, who had been Director of the Actuarial Course at ITAM.

<sup>10</sup>Once the IMSS Directorate lost its bid to control the IMSS health reform, CEDESS was gradually marginalized from the reform process until it was dismantled and handed over to the IMSS union, with the name of *Instituto de Estudios Sindicales para la Seguridad Social* (IESSS) in 1998. Key members like pensions leader Davila joined the Zedillo administration from its outset occupying formal positions within the government's economic team. This further hampered the CEDESS' horizontal networks, reducing its interaction – and that of the IMSS Directorate – with the economic team.

<sup>11</sup>Enrique Davila, former member of CEDESS in charge of pensions during the previous administration, was one of the members to join on behalf of the Ministry of Finance, where he now held a formal position.

<sup>12</sup>The National Committee for the Retirement Savings System.

<sup>13</sup>A change team had also been formed and positioned within the MOH to lead its reform, so the MOH officials who participated in this interagency group were not doctors, but economists who were former junior members of the economic team.

<sup>14</sup>This task was in fact not assigned for a long time – and the initiative languished in Congress – until taken up by Jose Antonio Gonzalez Fernandez, when he was appointed Health Minister in late 1999.

<sup>15</sup>Given the political costs of confronting the IMSS union without the full backing of the president, the IMSS Directorate did not have the incentives to see the opt-out policy regulation take shape, as it would be its responsibility to implement it. With the sole exception of Gabriel Martínez, IMSS officials invited to the interagency group used it as a forum to make their case that implementing the opt-out option was politically unfeasible.

<sup>16</sup>This included union leaders' declarations in the press that the government was secretly planning to "privatise" the IMSS, which was echoed by option party members.

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**PART IV**

**COMPARATIVE ANALYSIS AND CONCLUSIONS**

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## Chapter 8. Comparative Analysis

### 8.1 Introduction

This chapter presents the comparative analysis of the political dimension of health reform in Mexico and Colombia, based on the findings described in the preceding chapters. The analysis is supported in a series of propositions about the elements that contribute to the state's capacity to promote policy reform, and therefore, enhance the political feasibility of health reforms. The discussion links the findings in the two case studies to the literature review presented in chapter 1, as well as emerging themes and theoretical debates on the political economy of policy reforms and public management.

First, a reflection based on the case study findings on the political economy schools presented in chapter 1 – pluralism and new institutionalism – is presented. Then, the emerging themes related to New Public Management (NPM), organisational change, and strategic-choice model are introduced. Further on, the series of new propositions stemming from the literature and from the case study findings are discussed in comparative analysis. Following the analytical framework of this thesis, these are grouped in three clusters. Those related to the **political context** of reforms, those related to the reforms' **policy process**, and lastly, those related to the **change teams** that are put in charge of leading such reforms. The chapter ends with a brief recapitulation on the political feasibility of health reform in the light of the propositions explored.

In chapter 1 it was noted that there is no consensus about what a health reform entails. In fact, health sector reform points at the “current wave of interest in changing the policies, practices and management systems within the health sector” (Mills, 2001). Many of the health reform agendas that are currently underway have a common element in that they seek, in part or in whole, market solutions to problems such as limited resources, inefficiency and lack of quality in health care. These market solutions have been referred to in the health policy literature as *mixed market*, *internal market*, *quasi market mechanisms*, *regulated market*, *managed competition* and *public competition*, among others (Robinson and Le Grand, 1994; Basset, 1993; Culyer, 1990; Saltman and Van Otter, 1989).

In the UK, Australia and New Zealand, this underlying element in health reforms seeking to redefine the responsibilities of the government and the market in health service delivery, as well as to apply managerial tools from the private sector, has been named *New Public Management* (NPM) (Barzelay, 2001; Mills, 2001; Paton, 1997; Hunter and Stockford, 1997; Hood 1990 in Parsons, 1995). NPM marks a turning point from *administering* or running a health system, to *managing* it, reflecting the need to rely on leadership to seek quality and to make choices within a situation of limited resources (Paton, 1997). It concentrates on how policy makers should guide, manage and oversee public bureaucracies (Barzelay, 2001).

NPM draws from public management and a vast array of disciplines, such as scientific management, economics, social and occupational psychology, and management accounting, among others (Parsons, 1995). It offers a series of tools geared at improving the responsibility, accountability and performance of the public sector like separating policy making and service delivery functions, using contracts to define goals and responsibilities, enabling consumer choice, and using performance incentives and competition (Mills, 2001; Barzelay, 2001; Kaul 1997 and Haque, 1998 in Mills, 2001; Hood, 1991 in Hunter and Stockford, 1997).

The influence of management in public policy, as articulated in NPM, is not new (Mills, 2001). It stems from the introduction of management ideas in policy making and analysis in the US in the 1960's, which coalesced in what came to be known as public management in the 1970's, presenting a coherent critique – and alternative – to traditional public administration in the 1980's and 1990's (Hughes, 1994). This influence of private sector management innovation over public sector reform triggered organisational change in state institutions and the adoption of NPM. As private enterprises reconsidered mass production and centralised organisations, the public sector started to follow the trend – if at a much slower pace – towards more decentralised policy implementation and a higher degree of responsiveness towards service users (Hoggett, 1987 in Parsons, 1995).

As has been shown in the case studies, the health reform agendas of Mexico and Colombia in the 1990's, held many components that can be identified with what has been described as NPM. Both countries sought to improve the efficiency, the effectiveness and the quality of health care service delivery by reassigning the responsibility previously solely in the hands of the state, to the market, and by introducing market-like mechanisms in the old provider

institutions. To do so, they focused on two aspects. One was the creation of new private health delivery institutions that were to compete among each other. The other was the transformation of the old public provider institutions through the reallocation of resources and redefinition of the rules and incentives of their public health sectors.

Further research is needed to understand how these currently dominant ideas in the international health policy community<sup>1</sup> impact policy agendas at the local level. However, the case studies explored in this thesis have demonstrated that once this reform agenda has been adopted by policy makers, its feasibility, as well as its final policy content is greatly determined by the political context within which it is embedded, as well as the politics around the process it follows from problem formulation to consolidating the envisioned policy change. Thus, the case studies show that while the issues contained in NPM informed the health reform agenda in Mexico and Colombia, the analysis of its political feasibility remained in the political economy domain: in the factors that mediate the adoption of private sector management tools by the state.

It has been stressed throughout the thesis that what makes health reform a political process is the fact that its policy affects the interests of different groups in society and within the state (see also Fierlbeck, 1997). And that therefore, during a health reform process, these groups compete to influence policy definition, legislation and implementation in order to protect and pursue their interests. In Evans' words "... people – not just individuals, but rather well-defined and more or less self-aware sub-groups within the population – are pursuing very different objectives in any reform process" (Evans, 1998).

In chapter 1, two competing approaches to the political economy of policy change relevant to the analysis of health reforms were presented and critiqued. These were the interest group approach or pluralist school and the new institutionalism approach. As a result, a third alternative for analysing the political dimension of health reforms was suggested. One in which the focus of analysis is placed on the decision-makers in charge of pursuing health reform: the health change teams. The following sections present further elements for the critical comparison of these analytical approaches based on the findings of the two case studies.

## Interest Group Approach

The interest group approach or the pluralist school sees both reform definition and its policy outcome as the result of the struggle amongst social groups, also called stake-holders. According to this view, the political feasibility of a policy reform agenda depends on the difference between the power and number of the group of actors who favour the reform, and that of those who oppose it. Most importantly, this perspective assumes that the state is a neutral actor without an independent policy agenda. Therefore, the public agenda is defined and adjusted in reaction to the result of the competition among social actors striving to influence policy making (Schamis, 1999; Roderick, 1994; Dunleavy, 1991).

Evidence in both case studies presented in this thesis showed a political scenario in which those who stood to benefit from the reform – consumers – were weak and politically disorganised, and those who stood to lose – bureaucrats, providers – were powerful, organised groups; thus making the probability of health reform occurrence very low according to the interest group perspective. However, health reforms were launched and produced varying degrees of policy change in both countries. Further, in neither of these countries did the health reform agenda stem from the mobilisation of social groups in society, but instead, from policy makers within the state. Also, in neither case did the health reforms translate into – nor did they seek – a large increase in political support<sup>2</sup>. Instead, the experiences analysed in this thesis show that policy makers pursued a policy agenda that was crafted according to their values and ideology even when this was at the expense of public health providers, who were powerful interest groups.

An aspect in which Colombia and Mexico showed contrasting characteristics casts further doubts on the analytical strength of the interest group approach. This was the level of organisation and power of those interest groups that opposed the reform in each country and their impact in the reform process. In Mexico, the state bureaucracy and the public provider groups have historically played a key role as intermediaries between the state and society through service delivery (Gonzalez-Rossetti et al., 1994), and were organised in powerful unions with strong links to the party then in power. On the other hand, Colombia's public provider unions were but a small fraction of the labour force and were quite fragmented, and as a consequence, their political leverage was quite limited in comparison to the Mexican case.

In light of these contrasting scenarios, the interest group approach would lead to expect less organised resistance in Colombia and therefore, better chances for its health reform's consolidation. However, the empirical evidence of the case studies showed that while in Colombia reformers were able to make significant progress in the creation of new private health providers, they were equally unable to implement the transformation of the old provider institutions where these interest groups had their stakes. These findings suggest that there are other factors mediating the power relations between the policy makers pursuing reform and the interest groups affected by it. By the same token, it can be argued that the pluralist approach lacks the tools needed to fine-tune the analysis and understand policy outcomes such as these.

### New Institutionalism

In chapter 1 it was argued that the elements that could strengthen the political analysis of health reforms were the factors mediating state-society relations and the power struggle among interest groups. A country's political institutions that define the rules of the game by which such competition takes place (Immergut, 1990; Steinmo et al. 1992; Linz and Valenzuela, 1994; Liphart and Waisman, 1996; Bates and Krueger, 1993). Institutions offer access to decision making to some groups, while blocking the participation of others; give opportunities for action to some actors – regardless of their intrinsic power as defined by the pluralist school –, while limiting the political action of others. In doing so, the institutional setting has a determinant role in the political feasibility of a reform initiative and its outcome.

Most importantly, it has been stressed that this approach throws light on the processes within the state. Instead of considering the state as a monolithic actor, it “opens the black box” and enquires about the competition to influence policy making that takes place among those groups that are within the state or form part of it. This added dimension to the mere competition among interest groups in society reflects the more complex political dynamics that take place during a reform process. One in which policy makers pursue their policy agendas with some degree of independence from interest group pressure, within the opportunities and limitations that the institutional setting offers both to them and to all actors involved.

Evidence in both the Colombian and the Mexican case studies pointed to the importance of institutions in determining the political dynamics around health reforms and their feasibility. In both countries the Executive was more powerful than Congress. As a result, it was found that competition to influence the health reform formulation occurred mostly within the Executive, and not in Congress. While this did not eliminate interest group participation in policy decision making totally, it reduced it to the very few groups that were able to access decision-makers within the Executive. The comparative analysis of the interactions of these factors affecting health reform will be discussed below.

Another element of new institutionalism reviewed in chapter 1 is the policy node. Policy nodes are the instances in which the health reform initiative can be altered, promoted or brought to a halt. These policy nodes are located in different points of the institutional setting of each country, such as the Executive, Congress, and public sector agencies. Immergut refers to them as veto points or “veto opportunities arising from the design of political institutions...(which) ... explain both interest group influence and the effects of political institutions on policy results.” (Immergut, 1990:398). As a result of this somehow narrower definition of the times and places in which policy decision making affecting the reform is taking place, much of the scholarly debate has focused on the number of veto points to assess the political feasibility of reforms, instead of analysing the nature of these policy nodes and the profile of the actors within them. For instance, the cases in this thesis have shown that the actors in policy nodes located within the health service provider organisations – such as the social security institutes – were ideologically opposed to the market mechanisms; which was not the case in policy nodes within the finance and planning ministries.

An analytical tool is needed to reflect upon and delve into the interactions among decision-makers and other actors that take place within the institutional context that has been referred to. Further, what is needed is to trace in an orderly manner the process in which a health reform evolves in its context and the interactions among actors during the process. Grindle (2001) has pointed to the limitations of the new institutionalist approach in analysing the interactions between actors and has thus endorsed the use of a process approach to overcome them. Nelson (1999) has also studied in detail the varying political dynamics at each stage of the reform process. In the study of health politics Walt and Gilson (1994) and Altenstetter (1997) have proposed the use of policy process as a tool for analysis to be examined in tandem with a reform’s policy content and the actors involved in both.

Given that in the two case studies health reform initiatives have been promoted by government, it is of particular importance to analyse the groups of policy makers that were in charge of promoting the state's reform agenda at important parts of the policy process- that is, the change teams. Thus, taking into account the analysis of the political context and the policy process of health reforms, this thesis has focused its analysis on these groups of decision-makers in charge of the reform and how they operated within their particular political context throughout the policy process.

### Change teams

The Mexican and Colombian case studies showed that while some interest groups outside government discussed and sometimes pressed for health policy change, the issue did not reach the government's agenda in full until these small groups of senior policy makers took it on board. Colombia presented what seemed to be a counter example, since it was the interest groups represented in the temporarily empowered Congress, who first pressed for a thorough health sector reform. However, as it is presented in the case study, this first impulse dwindled and would have resulted in a series of marginal changes, had it not been championed by a health change team within the Executive with the backing of the president.

Once these groups of decision-makers incorporate the issue onto their policy agenda, they considered a series of factors and design strategies to promote it. Public management points to the importance of this aspect of policy reform through the strategic-choice model or strategic change (Morgan, 1986 in Parsons, 1995). Strategic change evokes the need of public sector reformers to take into consideration the political environment in which their organisations function in order to make the choices that will best serve their reform agenda (strategic choices)<sup>3</sup>. The strategic choice approach focuses on change teams (which it calls the dominant coalition): The group of decision-makers with a reform agenda in charge of making such strategic choices, are also referred to in the literature as *reform entrepreneurs*, or *champions* (Grindle, 2001; Srinivasan, 1985).

As discussed further on, it is the institutional context that determines the potential for these groups of reformers to be convened and empowered by senior policy makers, as well as the margin of manoeuvre with which they are able to pursue their policy agenda. In the case of Colombia and Mexico, the existence of strong Executives and weak legislatures enabled the

use of change teams in policy formulation, and in brokering the reforms. As described in earlier chapters, this was also due to the fact that the Executive in both countries concentrated the policy tools, the information and the human capital to do so. Further, in both countries, the absence of a professional civil service made the Executive rely on what has been described as “pockets of efficiency” (Geddes, 1994) – concentrated in the finance and planning ministries and on the president’s staff - to develop and follow up its policy agenda. The technocratic groups in these positions played technical but also political roles in promoting the reform agenda - along the lines of the *Grand Corps* in France, which also has a strong presidentialist tradition (Suleiman, 1974).

The formation and use of change teams has been presented as the logical extension of this arrangement (Geddes, 1994; Schneider, 1991; Centeno, 1994). It has further been noted that they operate in contexts where political power is concentrated in the Executive and the participation of social actors in policy decision making is limited (Williamson and Haggard, 1994). And this brings us back to the analysis of the political context in which the reform process takes place. Following the analytical framework that this thesis has presented, the following sections will review some of the relevant propositions in the political economy debate pertaining to the context, the process and the change teams involved in policy reform in the light of the Colombian and Mexican experiences with health reform in the 1990’s.

## 8.2 Political Context

The findings in the case studies point to the importance of the role played by the institutional context in structuring state-society relations and their influence on the health reform process. In this section 2 propositions are discussed in light of the evidence gathered in the case studies regarding the political context in which the health reforms evolved. They stem from the issues that are most salient in the political economy of policy reform in what pertains to the political context, and are the influence of **regime type** on the political feasibility of policy reforms, and the opportunities and limitations embedded in the **political system** of each country for the pursuance of a reform initiative.



## Influence of regime type

Chapter 1 pointed out a dominant trend in the political economy literature that relates a country's political regime to the chances of successfully realising a reform agenda. In general, it is argued, launching reforms in democracies is a longer and more complex process than in dictatorships<sup>4</sup>. In other words, even though an authoritarian regime may have to "educate public opinion and negotiate with divergent pressure groups, it may be able to act more quickly because it can negotiate from a position of power"(Ardito-Barletta, 1994:463). However, this view has been countered by comparative studies that have shown no relevant correlation between the chances of promoting policy change and regime type (Remmer, 1990; Nelson; 1990, Bates and Krueger, 1993).

One of the problematic factors of this academic debate is that classifying countries along the democratic-authoritarian axis forces an oversimplified divide (Remmer, 1990) that fails to specify the analytical tools to compare differences in state-society relations during policy reform. Using this criterion Mexico is classified as authoritarian, and Colombia as "unambiguously democratic"(Williamson and Haggard, 1994). However, evidence from the two case studies suggested that both countries shared political characteristics that would classify them on the same side of the spectrum. If elections are taken as a measure of regime type, the cases showed that both Mexico and Colombia have held regular elections in the last 8 decades with the exception of a short lived military government in Colombia. Haggard and Kaufman state that "elections in authoritarian regimes are, by definition, not wholly competitive" (Haggard, and Kaufman, 1992: 31). The case studies of both Mexico and Colombia have stressed that this has been the case in both countries. So it could be argued that classifying Mexico as an authoritarian regime and Colombia as a democratic one, has been largely based on political party rotation, since the former had a single party system in power for seventy years and the latter has rotated power between the two traditional parties in the late 1950's.

Established democracies like the US and the UK have had a similar pattern of party rotation, which, however, has been the outcome of free elections. In the case of Colombia until 1986, this was the result of a formal elite mechanism to share power (see chapter 5). Proposing the use of inclusiveness as one of the variables to refine the classification of regime type, Remmer (1990) classifies Colombia as "exclusionary democracy" and Mexico as

“inclusionary authoritarian”. However, this classification still does not account for the evidence presented in this thesis, which shows that both countries a hybrid between democratic and authoritarian regime<sup>5</sup>: one in which through formal political institutions – the single party corporatist arrangement in Mexico and the National Front in Colombia -, the ruling elites secured their hold on power eliminating effective electoral competition, establishing an informal institutional mechanism to rotate the presidency and government positions, and limiting the political participation of social groups – and parties – in policy decision making.

While these informal institutional arrangements would predict very little variation in the ideology of the different governments – along the lines of authoritarian regimes -<sup>6</sup>, Ward (1994) has shown that Mexico has moved along the ideological axis in what he calls the pendulum theory. In chapter 5 it is suggested that Colombia has undergone similar ideological shifts, in spite of the fact that there too, as a result of the political pact eliminating party competition, parties lost all incentives to present clearly distinct ideological positions.

The fact that, as shown in the case studies, both countries presented a very similar pattern of ideological shifts and these did not result from free and competitive elections, suggests that the relevant question for the comparative analysis of Mexico and Colombia is not regime type, but instead the “degree of pluralism permitted” (Williamson and Haggard, 1994). That is, the formal and informal institutional attributions of each country’s political system that determine where and how interest group competition takes place during the policy process, so as to have an impact in the ideology permeating the state’s policy agenda. Among these are the characteristics of the political system, and the formal and informal rules of the game determining the balance of powers, which will be discussed in the following section.

### **Political System**

In contrast to the pluralist perspective discussed earlier, recent scholarly work on the political economy of reforms has suggested that political and policy outcomes cannot be understood solely as a result of the sum of societal interests; be it in the economic sector, or in the social sphere; but in combination with the political context in which they interact. More specifically, the characteristics of the party system and the Executive-Legislative balance of power (Haggard, 1994; Immergut, 1990).

Both Mexico and Colombia have strong presidential systems (Kaufman, 1999) and therefore weak legislatures. This has led to two significant results. Firstly, in both countries, the single most important source of legislative proposals is the Executive; and secondly, that it enjoys a high degree of independence from Congress in promoting its reform agenda. In the case of the health reform agenda, examined at length in the preceding chapters, formal institutional rules required that health reform initiatives be legislated and approved in Congress in both Colombia and Mexico. But in both cases the strong presidential power established in their Constitutions – as well as the informal or unwritten institutional features – gave pre-eminence to the Executives in defining the reform's policy content.

In Colombia's case, Congress enjoyed a period of temporary leverage vis-à-vis the Executive as a result of the new Constitution and the political reform that was taking place. This enabled legislators to condition the pensions reform to include health reform on the same bill. Yet once the Executive assumed the health reform agenda as its own, the Congress lost control over it, and was reduced to a reactive role. In the case of Mexico, when the inclusion of the health reform on the new Social Security Law was considered, the party in power still enjoyed an absolute majority in Congress. Under these circumstances, the decision to reduce the reform's scope was not a result of negotiations in Congress, but rather of political calculations within the Executive made prior to the presentation of the reform initiative to the Legislature.

In both countries, the informal institutional features that concentrated power in the presidents as individuals, played a key role in determining the Executive's degree of leverage *vis a vis* Congress. The Colombia case study showed how, when negotiations in Congress had reached a stalemate in spite of the brokerage of the economic and health change teams, the president was able to supersede political competition and bargaining in Congress, and secure a cupular arrangement between the two traditional parties that guaranteed enough votes to legislate the reform.

Also, the informal institutional features of the Mexican political system enabled the president to establish a clear cut division of labour between the technocratic groups within the Executive – entrusting them with policy formulation -, and the members of his party, who, while not allowed into the decision-making room – and therefore having no ownership over

the reform agenda -, were put in charge of brokering it within the party itself at first, and then in Congress.

As a result of the strength of the Executive vis-à-vis Congress in both countries, political competition and policy debate was transferred from the wider social arena to a narrower one within the state, where most of the reform's policy process took place away from public scrutiny. This converted the government - more precisely, the senior level bureaucracy - into the single most important veto point in the political system. One where the prospects of the reform and its final content were defined by limiting and selecting the access of societal actors interested in influencing it. In studying the French health reform Immergut (1990) had found a similar situation: one in which "because Executive decisions could not be vetoed elsewhere, political negotiation tended to be contained within the Executive arena" (Immergut, 1990:396). The study of bureaucratic politics and competition within the Executive becomes then central to explain how different factions of policy-makers with different ideologies confront one another.

One of the aspects that come to the fore is the fact that if political competition to influence policy definition is transferred within the Executive, then far from being a monolithic block, the Executive sends "contradictory signals from different policy centres" (Williamson and Haggard, 1994:594). The case studies showed that regardless of the party in power, the full ideological spectre from pro-market to pro-State positions was represented among the different government factions. The 'control' ministries and the 'spending' or 'constituent' ministries (Haggard, 1994) ran along ideological lines where the former saw a diminished role for the state, whereas the latter defended state intervention. In studying the politics of social security and health reform in Poland, Hausner (1998) and Duffy (1997) found similar inter-ministerial competition within the Executive also stemming from differences in ideological stand.

However, in spite of the institutional fragmentation due to competition to influence policy within the state, governments in Mexico and Colombia did have policy agendas with a coherent ideological profile and a single direction. This means that other factors were at play within the state that resolved this conflict and ensured a coherent plan of action. In the case of Colombia, the fierce competition around social security and health reforms between the pro-market and pro-state factions was brought to a halt by the president, who dismissed those

opposing the change team's reform agenda; and ensured that policy makers sympathetic to the reform were put in key positions. In Mexico, the power concentrated in the 'control' ministries and the presidency was such that there was no need to ensure the homogeneity of senior officers in the ministries to be reformed.

The other factor that served as a counterbalance to this internal fragmentation enabling governments to pursue a single policy agenda were the change teams and interagency groups. The presence of change teams – with different labels – as mechanisms to counter institutional fragmentation is noted by Suleiman (1974) in France and by Schneider (1991), Evans (1985) and Geddes (1994) in Brazil. Their characteristics and role in the reform process will be discussed further on in this chapter.

### 8.3 Policy Process

This thesis has stressed the relevance of the policy process variable as a key element in the analysis of the political dimension of health reforms. The dynamic characteristic of this variable helps explain the different political conditions around a health reform initiative as it evolves in time and space through its different stages<sup>7</sup>. This section will address 2 propositions to underline the importance of considering these two dimensions – time and space – when assessing the political feasibility of health reform. The first proposition (space) stems from the comparative analysis of the two case studies presented in this thesis and it relates to the existence of **parallel arenas** in the political context in which, in a simultaneous manner, health reforms are discussed and negotiated. The second proposition (time) stems from recent political economy literature on policy reform, and it relates to the different nature – and political consequences – of the **two “moments”** of a health reform process.

#### Parallel arenas

Based on the comparative analysis of the findings described in the case studies, this section seeks to sustain the proposition that parallel arenas exist during the health reform process, that they have different political dynamics and as a result, they generate dissimilar policy proposals.

The findings in both Mexico and Colombia case studies, point to the large public debates in diverse fora hosted or promoted by civil society, but also by the governments pursuing health reform. As it has been shown in chapters 3, in Colombia social groups participation was ample even before the health reform was incorporated into the public agenda by the state. Groups with different ideological stands proposed and critiqued competing proposals on the features the new health system should have. The particular political circumstance that Colombia was undergoing with the writing of a new Constitution and political reform, also encouraged unusual levels of political participation and public debate. Colombia's Congress and its National Constituent Assembly were centre stage to these debates. Later on, when the Executive took the health reform banner as its own, it constantly promoted instances for public debate and dialogue both among social actors themselves, and between these and government officials.

In a much smaller scale, the debate about health reform also reached public opinion in Mexico through social actors before the State made it part of its policy agenda (see chapter 6). Several groups in society debated different health reform options and competed among each other to gain influence over policy decision making. Most importantly, once the Executive had the social security reform in its agenda, it convened the key actors in the sector, sponsored its thorough assessment, and encouraged the preparation of policy solutions for the problems that were identified. These were formally presented to the President.

The number of these public fora – and in the case of Colombia - the high levels of participation in them, would give the misleading perception that the health reform process in these two countries was based on an inclusive and participatory public policy debate.

The careful observation of the policy nodes where the reform process took place in these countries, this is, the time and the place of the different stages of the reform process, reveal a different picture. One in which, in both countries, problem definition and reform formulation was taking place simultaneously but independently of these public fora.

The political dynamics in these parallel arenas showed marked differences: the public fora gave priority to participation as a source of legitimacy at the expense of swift decision making. Participants sought to build political support for their proposals as a means to incorporate them into the public agenda. Instead, policy decision-makers formulating policy

insulated from the public debate, prioritised efficient decision making over participation. The different factions within the Executive strove to make their proposals prevail on the public agenda through technical debate and bureaucratic politics. As a result, the reform proposals stemming from these parallel arenas bore very little resemblance with the exception of those cases in which the state had manipulated the debate.

In both case studies, the outcome of the internal competition to influence policy definition within the state, prevailed over the results of the several public fora - a factor that explains in great part the prevalence of NPM solutions and pro-market mechanisms in both country's health reforms, even though when they were largely criticised in these more open arenas. Further research is needed on how interest groups whose stakes are at risk – such as unions – make use of these fora.

#### The two “moments” of the health reform process

The analytical framework of this thesis a standard form to divide the reform process into anchor stages is used (see chapter 1): problem definition, policy formulation, legislation, regulation, implementation and consolidation. It has been stressed that in each of these stages, the policy reform passes through different policy nodes whose political dynamics affect the reform's content and the feasibility of its being pursued into the following stages of the policy process. An emerging theme in the literature is pointing at a possible relevant approach that classifies these stages in the policy process into two overarching "moments"<sup>8</sup>: one that comprises problem definition, policy formulation, legislation and regulation (which will be called initiation); and another comprising policy implementation and consolidation (which will be called consolidation).

There is an underlying element of the interest group approach in this proposition to divide the reform process in two moments. The emphasis on the fact that the reforms may affect entrenched interests at their outset, but will only produce tangible benefits in the long run - as well as the characteristics of the losers and winners of this sequence -, lies at the heart of the pluralist explanation about the unlikeness of reform. This “short-term losses and long term gains” factor informs the scholarly debate that is being framed in this “two moment” proposition. The challenge, it has been stressed, is to ensure that the reform initiative

“survives” long enough for it to accrue tangible benefits and thus acquire political support in its own right (Williamson and Haggard, 1994; Nelson, 1998).

Scholarly debate has concentrated on the strategy options reformers have to ponder to this end. And here is where the “initiation moment” and the “consolidation moment” seem to require opposite approaches to solving this challenge. Haggard (1994) has argued that during the reforms “initiation stage”, reformers face the resistance of the interest groups who benefit from the status-quo. Reform initiation, he claims “is thus more likely when Executives and their teams enjoy a degree of independence or autonomy” (Haggard, 1994: 468).

On the other hand, because second generation reforms like health not only require “price” changes, but profound changes in the incentives, benefits and costs of those groups in charge of producing change, their consolidation moment requires their consent or compliance. In a comparative study of health reform in Germany and the Netherlands, Lieverdink and Van der Made (1997) note that reform proposals may enjoy support at first, when they present abstract policy problems and solutions that cannot be related to particularist interests. However, resistance emerges when these solutions are translated into plans with tangible consequences for provider groups.

Thus, while the initiation moment may call for insulation to make health reform feasible, the consolidation moment may require the active nurturing of political support. While some authors claim that generating tangible benefits is a sufficient condition to generate support (Sachs 1994, also see Williamson 1994), others see the need to seek consensus and endow the reform with a certain degree of legitimacy if it is going to stand a chance of bringing about policy change. In other words procedural legitimacy defined as “the widespread perception that not only the formal rules but also the spirit of open and fair debate were observed and that all major interested groups had an opportunity to state their case (Nelson, 1998: 41). Interestingly, procedural legitimacy needs to be obtained during the initiation moment. Haggard acknowledges that the “consolidation of reform demands the building of legislative and interest-group bases of support” (Haggard, 1994: 468).

The observation span of the Colombia case study does not allow for conclusive remarks in this aspect, since the health reform there is currently on its consolidation moment. However, tentatively, it could be argued that the lack of consistency between what was legislated and



what has been implemented so far – particularly the failure to transform the ISS -, could be attributed in part to this lack of procedural legitimacy. Studying health reform in Poland and Hungary, Nelson (1998) also found that the reforms did not have procedural legitimacy since the governments “side-stepped public debate and legislative approval” (Nelson, 1998:39); and therefore had very little chances of reaching consolidation.

And this brings us back to the existence of parallel arenas discussed in the previous section. It could be argued that by firmly insulating their change teams within the Executive, while at the same time complying *pro forma* with the requirement for social participation and policy debate in public fora, governments in Mexico and Colombia were seeking to respond to the contradictory requirements of the reform process: insulation in the initiation moment, followed by the demand for social participation and procedural legitimacy that needed to be met prior to starting the consolidation moment<sup>9</sup>.

The evidence gathered in the two case studies is not sufficient to advance a firm conclusion on this issue, since at the moment field work was terminated, Colombia had only recently entered its consolidation moment, and Mexico was yet to start. Therefore the thrust of the thesis’ analysis focuses on the initiation moment of health reforms, which bare the characteristics of second generation reforms. The issue about the contradictory demands of the two reform moments described in this section, and how reformers respond to them – and with what level of success –remains an open question for further research.

#### **8.4 Change Teams and Health Sector Reform**

In the thesis it has been argued that the use of change teams in health sector reforms was a distinctive political strategy aimed at increasing the state’s capacity to promote health policy change, and that these groups of policy- makers could be distinguished as such by team members themselves and by other actors involved in the reform process. This section will analyse a series of propositions related to the use of change teams as a political strategy to promote health reform – an their **characteristics** -, their **political manoeuvring**, and their **choice of strategies** in pursuing health policy change.

As stated in chapters 1, 4 and 7, the precedents for the creation and use of change teams of a similar nature in Colombia and Mexico could be traced back to the processes of selective

state modernisation centred around the core economic ministries in both countries where “pockets of efficiency” (Geddes, 1994) were created from the 1960’s and remained firmly in place thereafter. The use of change teams as a strategy was first used to bring about economic reform. Once these were under way, the technocratic governments in power at the time in both countries, turned to the same strategy to bring about policy change in the social sphere.

Following a comparative study of 15 countries which attempted economic reform, Williamson and Haggard (1994) concluded that “a good and united team is a precondition for reform to have a chance” (Williamson and Haggard, 1994: 579). In the case of health reforms, change teams – although not always labelled as such - have been used in Poland (Hauser, 1998), United Kingdom (Hunter and Stockford, 1997), Mali (Fatourmata, El Abassi et al., 1997), and Chile (Borzutzky, 1998), among others.

In Colombia and Mexico policy-makers in the core economic ministries resorted to the formation and empowerment of change teams as a strategy to spearhead health reforms. They did so by assigning junior members of their own economic team to key positions needed to promote change within the health sector agencies and thus secured a direct line of influence. The health change teams were assigned the leadership of the reform. This entailed not only the reform’s policy, but decision- making on the political strategies to secure support around it. Thus they were expected to go beyond the purely technical field and into the political aspect of the health reform process.

They did so through a choice of political strategies aimed at gaining leverage as a team and protecting their reform project from bureaucratic factional competition at first. These were followed by other strategies geared to ensuring its legislation, and then to putting in place the policy mechanisms expected to bring about change – such as resource reallocation and new regulation. One of the main findings presented in this thesis are the marked similarities between these political strategies and those applied by similar technocratic teams in charge of economic reforms in these countries. Owing to the fact that in both cases the pro-market stance supported by the economic teams prevailed, emphasis was placed on putting public finances on a sound footing and the search for a more efficient provision of health services. By the same token, the choice of strategies to bring about health reforms in both countries – including the creation and empowerment of health change teams – was informed by the

economic teams' reform experience and their assumption that a similar approach – both in policy content and strategy choice – could be embraced in second generation reforms as well. In this section it will be argued that although these strategies were effective in the creation of new providers and the introduction of market incentives in the health sector, they did not have the same impact on the transformation of the old provider institutions – such as the health ministries and social security institutes – and that this has considerably limited the progress and consolidation of the reforms.

Change team members in both case studies presented themselves as apolitical and saw political manoeuvring as a lesser task. However, if the difference between a change team and a group of technical experts is the fact that the former is assigned the power and the responsibility to make the reform politically feasible – as explained in chapter 1 -, then it follows that the change team members did need to “exercise the skills validated by traditional political practice ... (relegating) ... the agenda of normative economics ... to a second place (...)” (Toye, 1994: 38).

Health change teams were able to engage in political manoeuvring, to gain leverage, and pursue their reform agendas due to the characteristics of the political contexts of Mexico and Colombia. The relevant enabling factors for their empowerment and use were the Executive's formal and informal institutional prerogatives to present policy initiatives and govern by decree; weak Legislatures and strong Executives; and the presence of a powerful technocracy in core ministries with a common ideology and vision of state reform. These elements in the political context of the two case studies were also found to be relevant in the political mediation around health policy in France (Wilsford, 1991).

However, these contextual “enabling factors” do not automatically endow the change teams with the capacity to use effective political manoeuvring, and therefore, a more careful analysis of their characteristics and choice of strategies is required in the light of the challenges presented by the health reform process. Toye (1994) contends that just as politicians do not have the training and the skills of technocrats, the technocrats do not have the skills of politicians. Bates (1994) goes even further by arguing the technocrats are generally of an academic background and therefore they lack the normal prerequisites of political influence: wealth and power. This leads them to suggest that there should be a division of labour among the two groups if policy reform is to be successful. In studying the

politics of health reform in Brazil, Ribeiro (1996) points to the contrary: a case in which the technocrats in power manage to substitute traditional politics for their technical discourse. In the case of Mexico, as has been described in chapter 7, this is clearly the standing that was followed: change teams concentrated on the technical aspects of the reform and assigned the responsibility of brokering the reform – both in Congress and in society – to a politician. A similar case was pointed by Conaghan and Malloy (1990) in the economic reforms in Peru.

The case of Colombia is less clear (chapter 4). On the one hand the change team, and particularly its leader, got directly involved in political manoeuvring to ensure the political feasibility of the health reform. However, despite its visible presence in Congress, the change team relied on the advice and intervention of senior politicians who were veterans in manoeuvring in Congress to get the consent of reluctant legislators.

Thus, while agreeing with Williamson and Haggard's (1994) counter argument to Toye (1994) that political skills are not acquired through professional training and that therefore change team members are potentially able to learn the political skills they need through experience, the case studies in the thesis showed that there was a division of labour and therefore that politicians played a significant role in securing the support for the health reforms. This supports Bate's view that "in successful cases, the politicians took care of the politics, creating a political space for policy innovation by the technocrats (...)" (Bates, 1994: 33). On the same line, Ardito-Barletta (1994) sees as a positive scenario to have technocrats work alongside politicians to "establish a sustainable program of policy actions (a reform program)" (Ardito-Barletta, 1994:462).

#### **8.4.1 Change Team Characteristics**

The use of change teams as a strategy was followed under the assumption that it could bring about policy change in any sector – regardless of the match between the sector's specificity and the training of change team members – by applying universal liberal economic principles such as freedom of choice, market competition, and an emphasis on a subsidiary state – thus prioritising privatisation and targeted subsidies for the poor<sup>10</sup>. This assumption was further reinforced by the technocrats' view of state-society relations: one in which an oversized state did not serve the common good, but the interests of a few entrenched groups. This led change

teams to hear arguments pointing at a sector's particularities with suspicion, as these were perceived by them as efforts to protect vested interests against policy change.

In the case of the health reforms in Colombia and Mexico, with the exception of the very few, none of the change teams' members had extensive experience or knowledge of health economics or health policy prior to their arrival at the MOH and IMSS, respectively. In a very critical statement, Robert Evans points to this increasingly frequent phenomenon saying that "reform proposals find their way onto the agenda (...) in complete disregard not only of the evolving evidence on the determinants of health, but of that on the implications and consequences of different ways of organising and funding health care systems themselves" (Evans, 1998: 2).

The background, knowledge and previous policy experience of change team members were an important factor determining the content of their health reform proposals, the political strategies they chose in order to pursue them, and ultimately, their ability for political manoeuvring. For instance, in both cases, some of the health change team members had had previous experience in first generation reforms. Notably, change team leaders had participated in economic reform as junior members of the core ministries in each country. Thus they tended to formulate the policy content of their health reform proposals and to choose their political strategies to pursue them, along the lines and assumptions they had successfully used then. This explains the emphasis, in both reform initiatives, on triggering policy change through changes in rules and regulations and resource reallocation. It also explains in part these change teams' inability – or unwillingness – to press for reform in those areas needing the co-operation of health service provider groups – such as the unionised health manpower – and their preference, instead, to induce them to change through new regulation and market incentives generating competition.

#### **8.4.2 Change Team Political Manoeuvring**

The majority of the members of the change teams in Colombia and Mexico were "outsiders" in the health service agencies where they were located, and very few were doctors. The teams were thus perceived as an intrusion from another ministry and could not count on a base of support within their health sector. Instead, their political backing stemmed from senior policy-makers outside the sector, particularly from the government's economic team –

**vertical networks.** The political economy literature is assigning growing importance to the political support change teams need in order to be effective. For instance, case studies on Peru (Webb, 1994) and Brazil (Bresser Pereira, 1994) showed the presence of change teams at the helm of these countries' economic reform initiatives which failed to consolidate. In both instances, these change teams failed to obtain the political backing of senior politicians that would have endowed them with the leverage to broker their reform initiatives.

In both Colombia and Mexico, the support of the economic team and/or that of the president – vertical networks – was the *sine qua non* for the feasibility of health reform. In other words, while the provision of health services is bounded within the health sector, the political and economic consequences of a health reform are of such magnitude that the determining factors – and determinant actors – go beyond the MOH, and include the core ministries in control of the economy. In Colombia, the health reform suffered a serious threat when it lost the support of the economic team, a situation that was only resolved through the direct intervention of the president.

Mexico presented the most dramatic examples of the importance of the vertical network for the empowerment of health change teams and the political feasibility of their reform agendas. In one of the cases, the IMSS Director formed a group of highly qualified technical officers (the CEDESS) and mandated the preparation of a comprehensive reform proposal for the IMSS, which included the thorough reform of its health service provision. However, neither this team, nor its reform proposal obtained the backing of the government's economic team. As a result, in spite of the IMSS Director's direct political backing of CEDESS, this was unable to promote its reform initiative and was eventually sidelined and dismantled.

Secondly, a health change team was formed and assigned to a key location within the IMSS – the Finance Division – by a faction of the government's economic team. This group of highly trained officials foreign to the IMSS (the IMSS change team) was empowered and assigned the reform of the IMSS – including its health services – with particular emphasis on its financial aspect. But the IMSS change team's leverage was short-lived when the Finance Minister, its direct vertical network resigned. The IMSS team was not dismantled and continued to operate at the Financial Division, managing to make progress in the financial re-engineering of the IMSS. However, left with no support, it had to slow down its policy agenda and, above all, negotiate policy change with the vested interests within the IMSS,

notably the IMSS union. It is thus important to note that the economic team's endorsement is of such importance, that it does not need to make its resistance explicit, since its lack of support is enough to derail a health reform initiative.

Vertical networks are a *sine qua non*, but not sufficient to enable the change team to operate. Change teams need to build networks across sectors and policy nodes to facilitate the reform's process without the constant need for the backing of the top leadership who empowered them. Also, if the change teams are unable to build horizontal networks within the public health provider institutions, they may find their reform efforts halted or reversed once they leave office in spite of having enjoyed top level political backing while there. Thus, as part of its efforts to embed itself within the state, the change teams resort to **horizontal networks** with like-minded same-level peers in other agencies, particularly those of relevance to their reform agenda. These horizontal networks allow the change team to interact with other agencies independently – and many times in spite of – the head of the agency where they are located; obtaining vital information, but, above all, being able to make the case for its reform agenda with their peers without the need to constantly rely on cabinet members – to whom it may not have constant access. In the case of Colombia, team members profited from their networks at the DNP to obtain information and policy analysis support and to make their case about the health reform. They also joined efforts with a more powerful team, that of the pensions reform, which was brokering the reform from the Labour Ministry. This greatly strengthened the brokerage capacity of the health team in Congress.

In the case of Mexico, it could be argued that the IMSS change team remained in place and managed to continue pursuing its reform agenda – if at a much slower pace – thanks to its horizontal networks with former colleagues at the core ministries, who supported it and continued to work closely with it in spite of the loss of its vertical network. However, horizontal networks do not replace vertical networks in their capacity to empower a change team, so the scope and depth of policy change led by the IMSS change team was minimal.

Finally, in the case of Colombia, the health change team made a visible effort to establish horizontal networks within the MOH – in some cases by establishing lines of co-operation with MOH officials, and in others substituting them – as a means to buttress the chances of the health reform continuing once the team had left office. However, with few exceptions,

this strategy failed to become a network, and to offer a significant counterbalance to the MOH apparatus which did not pursue the reform agenda once the team was out of office.

Thus it could be argued that if the change team is unable to build horizontal networks within the ministry itself – via consensus-building and/or substituting personnel deep enough in the bureaucracy – it may find its reform efforts halted or reversed as soon as it leaves office, in spite of having enjoyed top-level political backing while working at the MOH.

State-society networks were sought half-heartedly by change teams in both Mexico and Colombia. Societal actors did not play a visible role in the competition between change teams and other government factions for control over the health reform, but nonetheless there were attempts by both the pro-state and the pro-market factions to court societal actors that could prove an element of political backing. These state-society networks were made up not only of unions and provider groups, but also of business groups, insurance companies and international actors, among others. They were then used as leverage in the political struggle and the policy debate within government.

The case studies in this thesis show, however, that the change teams did seek selective contacts with think tanks and other institutions outside the state in order to access information and knowledge on the health sector. A similar phenomenon occurred during the UK health reform (Hunter and Stockford, 1997). However, these contacts were unidirectional, in that they did not secure access to these groups to policy decision-makers. In both countries change teams sought and respected the advice of policy analysts who had the same academic background and technical command – particularly in economics; but in spite of this communications, for these organisations the State and policy decision making within it remained very much a “black box” see chapters 4 and 7).

### **8.4.3 Change Team Choice of Strategies**

Given that health reforms count on a tepid endorsement from public opinion, and are vigorously opposed by the entrenched interests who stand to lose, change teams are swiftly made aware of the need to develop and pursue political strategies in order to ensure the feasibility of their reform project. Strategies that had been used during first generation reforms and that health change teams turned to as well included the use of highly technical



policy content to limit the participation of other interested actors; the element of surprise; and the drafting of law and regulation away from public scrutiny.

The fact that the social sector presented a different challenge – in that the state needed to convince its provider groups to change their *modus operandi* in order to bring about policy change – did not seem to have an impact on the change teams' choice of strategy in both Colombia and Mexico. This underlines the ideological stand of reformers in both countries, which led them to assume that whatever changes did not occur in the short run, would happen in the mid to long term as a result of the market incentives and the NPM mechanisms put in motion by their reforms in the health sector.

Another plausible explanation is the fact that change teams were aware of the stark resistance their reform agenda would face during its implementation stage, and also of the power of those interest groups who stood to lose with it – notably the provider unions and the health sector bureaucracy. Further, they were aware that their leverage – and their permanence in the health provider institutions – was temporary and that it would not last as long as the reform process would require to consolidate. Faced with this scenario, they resorted to the tools they had at hand – market mechanisms and NPM strategies – as a means to strengthen their reform agenda as much as possible before it faced the veto power of provider groups during its implementation stage. In other words, change teams sought to maximise their control over the reform and to introduce as many mechanisms to “lock-in” policy change before it was captured by the entrenched interest groups. The following strategy choices deserve particular emphasis.

### Speed and Scope

The political economy on policy reform has two contending propositions as to the best strategy to ensure the political feasibility of policy change. One stresses a comprehensive, one-time approach, and the other an incremental-phased approach. The supporters of the “big bang approach” (Przeworski, 1999) purport that it makes reversion to the *status quo ante* more difficult, and therefore opens an opportunity for reform to consolidate (Sachs, 1994; Piñera, 1994). Also, a one-time comprehensive approach would leave very little space for those groups opposing change to organise effective resistance. As a result of the analysis of health reform experience in the Netherlands, Schut (1995) and Baakman, Van der Made and

Mur-Veeman (1989) coincide in the need to use the “surprise” effect of comprehensive one-time reform as the only means to break the resistance of the powerful corporatist groups in that country. A comparative study on the politics of health reform in the UK and Germany arrived at a similar conclusion (Giaimo and Manow, 1997).

As it has been shown in chapters 4 and 7, the change teams in Colombia and Mexico shared this sense of “urgency” about implementing their reform agenda. They acted by surprise and with very little experimentation, moving swiftly to change regulation and resource allocation as a “lock in” strategy that would deter policy reversal in the future. In studying health reform in the United Kingdom, Hunter and Stockford (1997) pointed to the same phenomenon: “Ministers ruled out the possibility of any pilots or any independent evaluation of the reforms, insisting instead that the radical changes they wished to introduce should commence throughout the NHS within two years of the reform document (...) being introduced” (Hunter and Stockford, 1997:78). As discussed in previous sections, while this strategy did prove to be effective in breaking initial resistance, there is serious debate as to whether the chances of reform consolidation have also been undermined by the same means.

Supporters of the incremental approach present different arguments. One is the need to create consensus and ensure that the actors that will be in charge of implementing policy change have a sense of “ownership” over the reform agenda (Nelson, 1999, Grindle and Thomas, 1991). The other points to the need to phase the reform in order to avoid jeopardising all affected actors at once and thus debilitating the reform (Nelson, 1994, 1989; Waterbury, 1989). In Ardito-Barletta’s words “the government constantly needs to re-evaluate how its policies and actions affect the stock of political capital which it needs to govern effectively (Ardito-Barletta, 1994:469)<sup>11</sup>. Further, Nelson (1998) points to the political advantages of producing at least some visible benefits at first to garner political support for the overall reform. In studying the politics of health reform in Mali, Fatoumata, El Abassi and Maiga (1997) point to the demonstration effect of introducing new centres delivering basic services as one of the key conditions for success.

This note withstanding, the findings of the two case studies in this thesis call for further research on this issue. In Colombia, social security enrolment went from 20.6% to 53% of the population, ensuring constant access to health care for the first time to social groups who had previously only had it sporadically (see appendix I). In the case of Mexico, 300,000 mostly

urban low income families were enrolled under a new social security mechanism, and thus granted constant access to health care for the first time as well (see appendix II). However, it is not clear that this large increase in beneficiaries translated into political support giving leverage to reformers confronting entrenched interests in the sector<sup>12</sup>. Further analysis has to be made, however, on the political role of the emerging intermediaries between the state and these new beneficiaries: the new provider institutions who have an economic stake in policy change and its consolidation, and who have been politically active to that end.

What remains a central argument in this thesis is that change teams in Colombia and Mexico had to make decisions on which aspect of their reform's policy agenda to develop first, at what speed, and the degree of "dependency" among the various elements included in the reform on the basis of political calculation. To simplify the argument, this thesis has reported that the technocratic groups in both Mexico and Colombia took into consideration the political dimension of health reform when deciding what to do first and how. In both cases, priority was given to the creation of new providers – who would not oppose the measure – and to postpone the transformation of the old provider institutions, which would have generated much resistance. Thus, while new actors were created and the conditions put in place for their operation, old providers failed to be transformed, at a great loss for the health system and its potential to consolidate policy change.

In the case of Colombia, where the health reform did reach its implementation stage, the transformation of old actors was left for a later stage or halted by status quo interests. It could be argued that the change teams postponed the transformation of the old actors as a strategy to ensure the political feasibility of a major part of their reforms: the creation of new actors and the introduction of market forces into the system. As has been stated, one of the assumptions behind this strategy was that market forces would induce the change that was being avoided by the state. In other words, in both Mexico and Colombia, reformers took this decision on the assumption that the new actors and the new rules of the game for the sector were eventually going to force old actors to change.

Yet another element that might have inclined change teams to this strategy is that contrary to the factors that triggered most economic reforms (see Williamson, 1994), the crisis or "collapse" of the health system does not happen at once and simultaneously. Instead, the sense of crisis is perceived in a protracted and dispersed manner<sup>13</sup>. As a result, instead of

being forced to a one-time reaction to crisis, change teams considered a more incremental approach in which the health system does not follow an overhaul overnight, but instead follows a series of policy changes each affecting the system on the margin until the sum of such interventions bring about the new system.

### Brokerage in Congress

Change teams adapted their brokerage strategy in Congress according to the particular characteristics of the political context in which they were operating. In the case of Colombia, where interest representation was dispersed and political parties failed to work as institutional channels to structure it, the change team approached Congress as if it were a group of individual voters and focused on those legislators who had an interest in the health issue and who could thus veto the reform initiative or significantly alter its policy content. These legislators were perceived by the change team as informal leaders who could sway the vote of the rest of the congressmen. In the case of Mexico, interest representation within the party that held the majority in Congress (the PRI) was structured along the lines of a corporatist arrangement, where leaders of each corporatist group (labour, peasants, the “popular” group) would secure the votes of their bloc. Thus the technocratic groups assigned the brokerage of the reform to a former president of the PRI who “knew the ropes” (the IMSS Director) and who held one-to-one negotiations with the leaders of each of these corporatist groups in order to secure the totality of the PRI’s votes.

### Choice of Legislation

In both case studies, the change teams – and in Mexico the inter-agency groups – carefully considered the content of the reform initiatives they presented to Congress from a political perspective. It was in fact, the only stage in the reform processes where in the two cases political considerations were given priority over technical orthodoxy. In the case of Mexico, the health reform was virtually brought to a halt by excluding it from the social security bill presented to Congress. This can be explained in two ways: the first is that the health reform component was perceived as a liability jeopardising the political feasibility of the pensions reform and was thus simply derailed. The second was that reformers believed that policy change in IMSS health services could be brought about with internal administrative acts without the need for a law amendment. This second account is coherent with the technocratic

groups' ideological stand and policy choices. It also suggests a strategy to circumvent Congress.

In the case of Colombia, the change team formulated its reform proposal in isolation until it "opened up" to lobby its approval in Congress. The bill that was eventually approved after arduous negotiations, lacked precision on most of the issues. This was supported by the team in part to accommodate the competing positions of the different actors involved in Congress and thus to ensure its approval. Ardito-Barletta (1994) considers this a strategy by which policy reform may be strengthened "by maintaining the broad guidelines of policy while retaining some flexibility and allowing many representative groups to participate in the policy negotiations" (Ardito-Barletta, 1994:463).

But also, Colombia's health change team supported a lax legislation because it ensured room for manoeuvre for the team which was to recuperate control over the reform during the preparation of its body of regulations – which could be developed in isolation and thus without interest group pressure<sup>14</sup>. In doing so, the team gave itself the opportunity to "bring back" the reform closer to its original project during the drafting of the regulations. But by the same token, it hampered the potential to consolidate the reform through legislation, since the new Law's general wording was also used by groups resisting change once the change team was no longer in office.

### Policy Dialogue

In both case studies, the change teams – or technocratic groups in the case of Mexico – explicitly isolated themselves and the reform process from the influence of other actors, and did so until the institutional rules of the game forced them to "open" the process. They made intermittent contacts with groups within the state and in society that were relevant to them due to their knowledge and information, but did not establish a systematic policy dialogue on equal terms giving these groups access to policy decision-making. In both countries reformers argued that reform formulation should be kept from being captured by organised vested interests trying to influence the reform's policy content in their favour.

This strategy choice can also be traced back to the economic teams which during first generation reforms had been successful in consolidating policy change by insulating the

reform process and circumventing interest representation mechanisms on the grounds that these were captured by powerful vested interests<sup>15</sup>. At that time, the systematic use of Executive and administrative decrees was also given priority over legislation. Yet the choice of this strategy in health reforms yielded mixed results. While it has proven successful in bringing about change in areas susceptible to changes in rules and regulations, it has not triggered the transformation of the old provider organisations, whose employees were effectively excluded from policy formulation.

However, concluding that this outcome can be attributed to the change teams' choice to insulate themselves and the reform processes may be an oversimplification. This brings back the argument to the interaction between reformers and interest groups analysed from the perspective of the institutional context in a previous section. While in both the political economy literature on reforms and the literature on the politics of health reforms it has been argued that insulating reform formulation from interest groups only makes politics "re-emerge through the fog of market and technocratic rhetoric" (Chinitz, 1997:253) during implementation, and that it might even exacerbate it (Grindle, 1994), these cases suggest the need for a complementary explanation. One in which actors opposing the reform may not "resurface" during implementation because they were denied access in previous stages of the reform process, but instead, perhaps preferred to act during implementation as a more effective strategy.

Such may be the case of unions and other provider groups within the state. While they may effectively be kept from participating in reform formulation, they might also not seek to force themselves into the decision-making room at that stage. Instead, they may focus more active strategies during reform legislation, where reformers are forced by the institutional rules to "open" the process. But unions and provider groups' leverage will become strongest during reform implementation, when policy change will depend on them. Thus, these interest groups against change would act then in order to press their demands and halt the reform process, independently from the strategy used by reformers in the prior stages of the reform process.

The issue calls for further research – which will acquire importance as health reforms approach their consolidation moment – on the workings of provider group reactions to policy change initiatives which they feel as foreign to them. Yet an alternative interpretation to the one suggested here that provider groups resisting change are not necessarily acting as a

reaction to the change teams' insulation strategy, but instead proactively choosing the strategic moment to exert resistance to policy change, points to the slow reaction these groups have shown in face of imminent policy change in cases such as the health reform in Colombia. According to this view, provider groups would only have "regrouped" to resist change during the reform's implementation stage because they took a long time to become aware or understand what was at stake in the reform agenda<sup>16</sup>.

### Inducing Change

Is the formation and use of change teams then an effective strategy to enhance the state's capacity to pursue health reform? The case studies in this thesis show that health reforms entail two critical changes: one that is related to changing the rules of the game (NPM) and creating new actors, by passing new laws and regulations and changing resource allocation; and another, that requires the transformation of the old actors - that is, the government agencies in charge of providing health services for the majority of the population. Thus, a reform would only be complete when it manages to create the new actors and to transform the old ones. Further, the Colombian case study has shown that as the health reform entered its consolidation phase, it became evident that when old actors fail to be transformed, they become serious obstacles for the consolidation of the new actors and for the overall advancement of the reform of the system as a whole (See appendix I).

Mexico recently legislated the creation of new provider actors, and thus it is too early to assess the end result of these measures. But in Colombia, the change team was successful in formulating reform, passing it through legislation and preparing it for implementation through regulation and resource reallocation. It created new actors and new rules of the game, generating market mechanisms within the health sector. But, be it for lack of time or for lack of political leverage to confront actors resisting change, the team was not successful in implementing the direct change of the old provider institutions.

Failing the direct short-term transformation of these old providers, the Colombian change team expected these to occur in the long-run and indirectly through market competition. In other words, it expected that by creating new – and in principle better – health care providers, it would give beneficiaries an alternative by which to move away from the old provider

institutions, thus forcing them to diminish in size and importance in the sector until they offered better quality care in a more efficient manner.

Thus it may be concluded that while the use of change teams has proven its effectiveness in inducing policy change through regulation and resource reallocation, it has failed to bring about the restructuring of the old public provider institutions, thus greatly limiting the scope of health sector reforms. In order to achieve the transformation of the old actors, interest groups that are normally excluded from the reform process – notably provider groups – need to be taken into consideration, either via consensus-building or confrontation. So far, given their nature and position, change teams seem to have a serious limitation in this respect, in that they have been unable or unwilling to do either.

### **8.5 The Political Feasibility of Health Reforms**

This brings us back to the economic teams which, from the core ministries in government, formed and empowered the health change teams as a strategy to reform the health sector. Since they were the health change teams' principal source of power, the economic teams delimited the former's margin for manoeuvre by revising how much political backing to give them at each stage of the health reform process. This had a direct effect on the political feasibility of the health reforms overall, and on the possibilities of pursuing its different components in particular, since health change teams were dependent on the leverage they were endowed with to pursue their health reform agenda.

This means that the dilemma to undertake a comprehensive health reform or not, was not in the realm of decision-making of the health change teams, but rather in that of senior members of the economic teams – and, ultimately, in the Presidents. As it has been stressed in both cases, these officials were concerned with preserving the minimum level of political capital that would allow them to pursue as many as possible of the components of their policy agenda. This was particularly evident in the relation between the health reform and the pensions reform, which were either competing items in the government's policy agenda (Mexico), or fed into each other (Colombia).

The health reform formulated by the health change teams in both countries presented the economic change team with two policy options. One was pursuing a comprehensive health



reform in the short run by creating new providers and directly transforming the old ones. The other was to phase the reform by creating the new providers in the short term, and indirectly triggering the transformation of the old ones through market competition – enabled by the creation of these new actors – in the long run. As has been evidenced in the case studies, the actors involved in the political dynamics around these two options were different, and so were the political costs and benefits of pursuing either or the two.

Particularly, the direct transformation of the old provider institutions in the short run entailed affecting the interests of large organised provider groups employed in the public health service agencies. As part of the state bureaucracy, these provider unions had a significant political role as intermediaries in state-society relations, since they interacted with society constantly at national level through their activities in health service delivery. They had historically exchanged their compliance and political backing to governments in office, in return for job security and employment and salary benefits. These groups resisted the reform and, more importantly, were not prepared to implement the transformation of the old provider agencies, since it put their interests at risk. Thus, the economic teams which were pondering their backing to the health change teams and their reform agenda, were back to facing what was described in chapter 1 as the “orthodox paradox”. That is, the need to lay the implementation of policy change in the hands of the actors resisting it.

Recently Hausener (1998) has suggested a possible solution to this dilemma. He purports that change teams should seek more policy dialogue while at the same time sustaining firm policy guidelines. Along the lines of NPM discussed earlier in this chapter, he calls it *strategic leadership and social partnership* and claims that “this juxtaposition involves no contradiction, as long as strategic leadership is understood as the capacity to form a strategic vision of the development of the system and to win democratic legitimisation for measures adopted for implementation (...)” (Hausner, 1998:36). Further research is needed to explore the potential of this proposition.

The findings in this thesis bring to the fore the centrality of the political dimension in health reform efforts on two related levels. Firstly, they lead to conclude that economic teams failed to give their political backing to the consolidation of the health reform initiatives, since the direct transformation of old provider agencies ran against organised state health manpower. And secondly, it underlines the fact that it was this lack of political backing that led health

change teams to an apparently contradictory strategy choice: one that relied on market competition to modify the incentives of these old provider groups, when their incentives were not dependent on market forces, but rather – and solely – on their collective labour contracts with the state.

With the creation of new providers on its way in both Mexico and Colombia, the transformation of these old providers will remain the critical pending issue for the consolidation of health reforms in both countries. And their transformation will remain political, as governments confront the need to sit at the negotiation table with state health manpower and workout what needs to change if policy reform is to be implemented. It is this political choice in which lies the key to consolidating new, more efficient and quality oriented health care systems in Colombia and Mexico.

## Footnotes for Chapter 8

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<sup>1</sup> See chapter 1.

<sup>2</sup> This note withstanding, President Gaviria's personal political backing of the reform once it was on the policy agenda requires further analysis. It could be argued that it was the reform's visibility and therefore its potential political returns what prompted his support.

<sup>3</sup> On how these strategic choices are made, see Alvarez and Gonzalez-Rossetti (1990).

<sup>4</sup> For a review of the academic debate about the role of political regimes in policy reforms see Haggard and Kaufman, 1992; Malloy, 1977; Remmer, 1990, among others.

<sup>5</sup> A point made by Centeno in analysing Mexico (Centeno, 1994).

<sup>6</sup> See chapters 2 and 5 for further discussion.

<sup>7</sup> Also for this reason, most of the issues relating to policy process are covered in the political context and change team sections in this chapter.

<sup>8</sup> They will be called *moments* as a means to distinguish them from the process stages they engulf.

<sup>9</sup> The argument is that beyond the different political dynamics at the micro level of the different policy nodes, these two moments present stark contrasts in the political interaction among key actors, as well as tangibly different challenges to reformers. In analysing first generation reforms, Haggard and Kaufman (1992) suggested that "(i)t is useful to draw a distinction between the initiation and the consolidation of reform efforts, because the political logic of the two phases is somewhat different" (Haggard and Kaufman, 1992). Also Nelson (1994) suggests looking at the reform process as two separate stages, each with particular political challenges, and thus demanding particular strategies.

<sup>10</sup> This phenomenon has been also observed in health reforms in the United Kingdom and the United States during the Thatcher and Reagan administrations. See Hunter and Stockform (1997) and Pierson (1994).

<sup>11</sup> Arditto-Barletta (1994) defines political capital as "the aggregation of support and credibility that a government may have at a given moment" (Arditto-Barletta, 1994:460). See also *Fragile Coalitions* (Nelson and Waterbury (eds.), 1989) for a thorough analysis on this matter.

<sup>12</sup> A possible explanation is that the new beneficiaries do not perceive their new entitlements as the result of a zero-sum game in a situation of scarce resources; but instead, as a result of the expansion of a welfare policy. If this is the case, the new beneficiaries would only have incentives to get mobilise politically to ensure the permanence of their new entitlements by pressing the governments to secure enough resources for that purpose, but not necessarily demanding the transformation or dismantling of the old provider institutions.

<sup>13</sup> In his study of health reform in Peru, Arroyo (2000) makes a strong argument about how "crisis" in the health reform is not a one-time event, but a long process of de-structurisation.

<sup>14</sup> This strategy shares the same rationale of the strategies used by the Colombian economic change team who preceded and supported the health change team. One that sought to accelerate economic liberalisation through administrative acts while the Legislature was not in session in order to side-step opposition (Urrutia, 1994).

<sup>15</sup> In studying health politics in France, and the elite bureaucracy in that country – which guards a high resemblance with the technocratic groups in presidentialist systems such as Mexico and Colombia, Freddi (1989) underscores these group's perceptions of themselves as guarding the national interest and therefore being "ill-disposed toward negotiation with interest groups" (Freddi, 1989:16). Bjorkman (1998) endorsed this view in studying the politics of health in the United States.

<sup>16</sup> I thank Joan Nelson for suggesting this idea while reviewing this chapter.

## Chapter 9. Conclusions

### 9.1 Introduction

This chapter starts with a brief recapitulation of the rationale for the thesis, the analytical framework it proposed, and the case studies it used. Then, the main argument is presented, followed by a profile of change teams and the factors enhancing their performance based on the cases presented in the thesis. The chapter ends with an agenda for further research and a synthesis of the thesis' contributions to knowledge and policy making.

### 9.2 Background

This thesis started with the premise that while the complexities of the technical aspect of health reform are not to be underestimated, the main factor determining the depth and scope of policy change is political in nature, and thus has to do with the interaction of the actors involved, their political strategies and their potential to influence the reform process. As a result, the political dimension of health reform formulation, legislation, implementation and consolidation needs to be brought to the foreground since it is a key factor in determining the feasibility of health policy change as well as its final outcome.

The comparative analysis undertaken in this thesis has shown that the study of the politics of health reform has an intrinsic value in advancing knowledge about the political dynamics involved in second generation reforms. Added value should result from testing an analytical framework that can be used as a tool for the rapid assessment of the political dimension of health reform initiatives elsewhere and thus help in the planning and the design of political strategies to strengthen the state's capacity to pursue its health reform agenda.

The **analytical framework** used for this thesis looked at the political context, the policy process, and change teams as three variables affecting the state's capacity to bring about health policy reform. This framework allowed for a systematic observation of the contextual factors determining the political feasibility of health policy change. It then looked into the use of change teams as a singular recognisable political strategy aimed at buttressing the state's capacity to pursue health sector reform. It explored the characteristics, political manoeuvring and choice of strategies of these groups of policy-makers to gain an understanding of how

they reacted to the political opportunities and limitations they confronted. In doing so, it has facilitated comparative analysis and has allowed for elements common to both case studies to surface as factors relevant to other health reform experiences.

Colombia and Mexico were selected as **case studies**. During the early 1990's, these two countries incorporated into their policy agendas health reform initiatives directed mainly at making health service provision more efficient. Both reform proposals were similar in the roles they assigned to the market and to the state in the articulation, financing and provision of health care. Their model or vision of how the new sector should operate was comprehensive on paper, with the introduction of new providers operating under new rules of market competition, and the transformation of the existing public institutions, or old providers into more efficient and user-responsive organisations also operating under the new rules. However, the political dynamics of both reform processes have thus far precluded them from developing in full. New providers were created and new rules introduced, but old actors remained the same, operating along the lines of the old system. This has put a question mark over the change teams' capacity to ensure reform consolidation in light of the political context within which they operate, as well as their characteristics and strategy choices. However, change teams were effective in initiating the reform process by ensuring the coherent formulation of a health reform agenda, ensuring its legislation, and preparing it for implementation.

### **9.3 The Argument: Context, Process and Change Teams in Health Sector Reform**

This thesis has argued that the political feasibility of health reforms was determined by the political context in which they evolved, the political dynamics of and around the policy process, and the characteristics and strategies of the change teams in charge of leading policy change. One of the clear findings suggests the importance of the role played by the institutional context in structuring state-society relations and their influence on the health reform process. This confirms recent scholarly work on the political economy of reforms, which state that political and policy outcomes cannot be understood solely as a result of societal interests (Haggard and Kaufman, 1995). In both Mexico and Colombia, it was the institutional context that determined the potential for the state, on the one hand, and societal actors, on the other, to influence the health reform's policy content. Therefore, the state's

capacity to pursue its reform agenda depended more on the country's institutional context than on the societal actors interested in influencing its content.

The formal institutional rules of governance were matched in relevance by the informal rules of the game that structured the interaction between societal groups and the policy-makers within the state. Beyond the formal relationship between the Executive and Congress, and the characteristics of the political party system, the informal mechanisms by which each country structured its politics – such as corporatist arrangements (Mexico) and inter-party governance agreements (Colombia) – also played an important role in determining which interests could influence the policy agenda and through which channels. As a result, informal arrangements were also an important element determining the Executive's leverage and control over **policy formulation**.

In **reform legislation**, in both Colombia and Mexico, formal institutional rules required that health reform initiatives be legislated and approved in Congress; but in both countries informal or unwritten institutional features – as well as the strong presidential power established in their Constitutions – turned the Executives into the principal legislative authority. Thus, most of the reform's policy process took place away from public scrutiny – with the exception of the legislation stage – and limited the use of institutional channels of interest representation – such as Congress – by societal actors interested in influencing the health reform.

The strength of the Executive vis-à-vis Congress and the resulting weakening of formal interest representation in reform formulation transferred political competition and policy debate from the wider social arena to a narrower one within the state. Bureaucratic politics and competition within the Executive were therefore central, and different factions of policy-makers reflecting a wide array of views and ideologies confronted each other.

Although interest representation was limited, and the centre of debate happened within the Executive, policy reform still required intense political manoeuvring, as different state factions struggled to have their policy projects prevail during reform formulation. The fact that the locus for political debate around the health reform projects was forced away from the formal channels of interest representation and into the Executive arena did not completely protract interest group participation, but instead limited it. Interest groups in society having

become aware that the key policy node in a reform process was the Executive, and not Congress, focused their political strategies towards gaining influence over the former. They did so by resorting to informal channels and elite contacts in an effort to gain access to key decision-makers. It was only when this approach failed, that these groups considered other means to press for access to decision-making, such as approaching representatives in Congress.

Inside the state, decision-makers who were competing to have their reform project prevail tried to avoid those interest groups that opposed it, while welcoming and nurturing links with those interest groups that favoured their proposal. Thus, coalitions in favour of and against health reform played their determinant battles within the Executive by resorting to support both within and outside the state.

In the two cases under study, the reform took place in the midst of a struggle between two major coalitions that supported different models of what the health sector should be and how it should function. These coalitions were made up of actors within and outside the state whose positions were based not only on issues of particular interest, but also on clear ideological premises as to the roles of the state and the market in the performance of the economy and the provision of services, the former, pro-market, and the latter, state-run. What determined the breadth and scope of the health reforms in the two countries has been the result of this political struggle.

The visible heads of both coalitions in Mexico and Colombia were within the state arena, occupying positions in different state agencies. The pro-market group had its support base in the economic and financial agencies, while the pro-state group had its support base in the agencies in charge of the provision of social services, such as health and social security. Thus while the main source of power of the first group stemmed from policy-makers at the highest level of the government hierarchy, the power of the latter stemmed from the capacity of its actors – the health manpower unions, the bureaucracy, and their links with traditional parties – for collective action and its control over the actual provision of the services – and thus over the reform's implementation.

While the institutional context gave the Executive enough leverage to secure a high degree of control over reform formulation and reform legislation, in neither of the cases studied did that

give it the means to also control **reform implementation**. In this stage of the reform process, those aspects of the reforms that required the transformation of public health services faced the effective resistance of public employees working in the old provider institutions – MOH and social security institutes – on whom the implementation depended. This was the case of bureaucracies and unionised health manpower in the social security institutes in both Mexico and Colombia.

This reveals the critical role of the political institutions over the state's capacity to bring about health reform from a different perspective: that of organised provider groups resisting policy change. It has been stated so far that the state was able to limit these entrenched interests' influence over reform formulation and legislation by maintaining the former within the Executive, and imposing the latter on Congress; and that it had failed to retain control over reform implementation. This explanation portrays provider groups resisting change as passive actors, and points to the need to explore alternative hypotheses, such as the possibility that provider groups are taking a more active stand and choosing their strategies based on the opportunities and limitations presented to them by the institutional context.

In this scenario, provider groups would have waited for the reform process to reach its implementation stage at the policy node in which they had the greatest leverage to influence the reform process. This second perspective would lead to a more balanced conclusion in which the state retained control over health reform formulation and legislation because it found the institutional means to do so, but also because provider groups resisting change only acted with full force during the reform implementation stage, where they could be most effective – or where they became aware of the reform's impact on their interests.

In either case, the more authoritarian the regime, the less access these groups will have to reform formulation and legislation, but in these two cases, the implementation of policy change will depend on them, and this gives them the opportunity to flex their muscles once the reform process reaches their realm. These provider groups' reaction to policy change presents a serious challenge for **reform consolidation**.

The case studies showed that the use of **change teams** in health sector reforms was a distinctive political strategy aimed at increasing the state's capacity to promote health policy change, and that these groups of policy-makers were distinguishable as such by the team



members themselves and by other actors involved in the reform process. Placing the focus of analysis on them proved key in explaining the politics of health reform, since they were a converging point reflecting the state's and society's strategies to influence the reform process.

Change teams were formed and empowered by governments with a health reform agenda as a political strategy to acquire a degree of autonomy *vis a vis* entrenched interests opposing change, and secure more control over reform formulation and legislation. This notwithstanding, change teams were able to trigger reform implementation, but not to ensure reform consolidation. The following section presents these change teams' profile and the factors enabling their performance that surfaced from the comparative analysis of the case studies.

#### **9.4 Change Team Profile**

The experiences analysed in this thesis show that the conformation and use of a change team has been a useful strategy to buttress the state's efforts to pursue health reform, particularly during its initiation stage. This section draws on the comparative analysis of the characteristics of these change teams to suggest a profile of their members, as well as factors that may help these groups promote health policy change.

The policy-makers and technical professionals of the change team must endow it with an array of policy and political skills that go beyond technical expertise. Aside from being capable to define the policy problems, and formulate and present policy solutions for them, they need to be knowledgeable on the specific features of the health sector they intend to transform, its key actors, and the context in which the reform process is to evolve. In a few words, the sum of each member's particular skills and professional experience must endow the team with the technical and political tools to formulate the health reform, secure its legislation, prepare it for implementation.

##### **Change Team Skill Mix**

The mix of technical training and policy experience of the health change team should yield, as a minimum, knowledge on health policy and economics, and health care systems; the

institutional memory of the policy processes that the system has undergone in the past, as well as the actors involved in them; brokerage capacity in the reform's key policy nodes; knowledge and command of law-making and public administration; capacity to articulate the reform's policy content in a simple message; and finally, media management skills.

Rather than concentrating on ideal professional profiles to compose the change team, policy makers interested in its use as a strategy should focus on ensuring the combination of these skills, which ought to be put to work once the group is assigned the responsibility of promoting health reform. In some cases, part of this expertise can be hired out, but this requires careful management in order to ensure its usefulness in the process. The case studies also pointed to the possibility of establishing a division of labour between the change team and senior politicians capable of brokering the reform. However, there was no conclusive evidence about the comparative advantage of either option – putting change team members in charge of brokering the reform, or leaving this in the hands of politicians. Based on the analysis of the case studies, the following table presents the list of skills that should ideally be present in a change team, and which will be briefly described next.

<b>Figure 9.1: Change Team's Mix of Skills</b>	
▫	Brokerage
▫	Institutional memory
▫	Health policy and economics
▫	Law making & public administration
▫	Articulation of reform message
▫	Communication management

**Brokerage:** The ability to communicate on one-to-one basis with actors involved in both high and low-level positions within the state bureaucracy; as well as to win the trust and negotiate with senior officials in the Executive, legislators in Congress and leaders of societal groups involved in the reform process. The brokers within the change team – be it a change team member or its leader – are the ground breakers for the change team and for the reform agenda in the different policy nodes through which it needs to pass.

**Institutional memory:** The knowledge of the health sector – and its key actors -, as well as health policy-related information stemming from holding previous positions in the sector - or related ministries. An added advantage should stem from having policy makers with previous positions in the core ministries such as finance and planning as change team members, since this endows the team with an entry point in these ministries - a crucial factor when brokering the reform within the Executive. Change team members who have participated in state reform while in previous public sector positions also endow the team with important experience and know-how on managing the reform process.

**Health policy and economics:** The technical expertise in the field and the ability to conduct highly specialised studies to tackle the reform's most complex issues is a key factor. Change team members with these skills should start activities as soon as the team is formed, anticipating the requirements of the reform process in the future, such as the formulation of the regulation package once the reform is legislated, or the operational plans once the reform is to be implemented. Given the division of labour among team members, those in charge of these activities normally work in isolation and are not exposed to political bargaining within the state bureaucracy or with interest groups in society.

**Law making and public administration:** The ability to convert the reform's policy content into law and make it applicable to the country's public administration. An expertise in regulation and knowledge of public law is crucial when the reform agenda entails to bring about policy change through modifications in rules and regulation. Team members with this expertise ensure the legal base of the team's policy proposals, and help to strengthen the team's position in the negotiations within the Executive and in Congress.

**Articulation of the reform message:** The ability to articulate the reform agenda to different publics - including public opinion in general. It requires translating the reform's some times highly technical and complex content into simple messages that can be understood and discussed in the policy nodes of the reform process. Also, this activity will form the basis for the communication strategy. The change team member responsible for articulating the reform may or may not become its visible head as well. When this last role is assumed by a doctor with "hands on" experience, there seems to be more potential for establishing channels of communication and cooperation with provider groups, who will not regard him as an outsider

– a situation that will necessarily surface given the training of change team members in disciplines other than medicine.

**Communication management:** The capacity to develop a media strategy to buttress public opinion support for the reform – and, by the same token, for the change team. The change team will require to design and conduct a media strategy in T.V., radio and the press around public health issues in order to introduce the reform to public opinion and garner its support. In spite the fact that this activity may be hired out, a change team member will need to have – or develop – the skills to relate to opinion leaders and the press, and thus ensure spaces for the team to explain an promote its reform agenda to public opinion.

The composition of the change team should change as little as possible in spite of the different demands each stage of the reform process will present. However, the organisation of the team should be such that the level of influence of its members should vary in order to ensure the flexibility needed to adapt the reform to these changing demands. Notably, depending on the stage of the reform process, the change team will have to confront the constant tension between the need for highly technical detail in the reform's policy content, and the need to apply political criteria - which may sometimes run counter to technical orthodoxy. If correctly managed, this tension between technical orthodoxy and political logic – and thus between change team members with profiles running along those lines -, should result in policy decision making that incorporates elements from both criteria, augmenting the feasibility of pursuing the reform agenda in a coherent direction.

On the other hand, it is of outmost importance that change team members have a minimum level of common ground both ideologically and in the vision of where the health system should head to. In other words, a change team can only operate if it acquires working capacity as a cohesive group. Having said that, it is also as important to count on divergent views – bounded by this common ground – to ensure the team's capacity to adjust its reform agenda through critical debate among its members – particularly if the change team is to remain insulated from more open policy debate.

For these dynamic processes within the change team to work in a constructive manner, the team should count on a clear leader. One capable of breaking the stalemate - if this is reached - and thus avoid paralysis. On the same line, the change team leader will have to respond to

the different challenges presented by the reform's political context and its policy process, by giving pre-eminence to the technical voices over the political ones or vice versa within the team, according to the circumstances. Beyond his role as tide breaker, the team leader will also probably be its principal broker within the Executive. Other members of the change team may take preponderant roles in relating the team to Congress and to public opinion, since these require different skills and networks. However, the change team leader will remain the most visible head of the reform. Both roles – tide breaker and visible head of the reform – make his ability to know when and how much of the policy content to compromise to secure political support a key factor in ensuring the overall survival of the reform.

Other critical factors in the performance of health change teams:

In order to avoid competing demands on their time – and possible commitments with other groups -, change team members should be assigned full time positions as members of this group. For this purpose, it is more likely that they be hired as a task force or group of advisors, instead of simultaneously holding formal positions within the Ministry of Health's structure. However, the characterisation of the change team as a task force does not mean it should have a short time span. On the contrary, the duration and permanence of the change team at the helm of the reform process is key to ensure its continuity and thus enhance its chances of consolidation. By the same token, although the change team may undergo several transformations throughout the reform process - through the inevitable replacement of some of its members -, all efforts should be made to preserve a core group or critical mass to preserve the mix of skills described above, as well as continuity both in policy content and the policy process.

The change team's technical capacity as well as its knowledge of the country's health care system should make it capable of absorbing the international policy trends on health reform, and "tropicalising" them to the country's needs and institutional capacity. By the same token, change team members should be in a position to having fruitful interaction with national and international health policy experts in order to learn and discuss the health sector's policy issues and enrich the reform agenda.

Although the change teams studied in this thesis favoured insulation over an open participatory process, they do not operate in a vacuum. Their mix of skills will not have any

impact on the reform's chances of success if they do not construct, protect and use a network of support around the reform and themselves. This network should reach key members of Congress, the Executive and other groups in and outside the state. In this manner, change teams may have the political backing they need to have leverage *vis a vis* the groups resisting change (vertical networks), channels of communication and coordination with their peers in other ministries relevant to the reform process (horizontal networks), and access to knowledge and information on health policy stemming from actors within and outside the state (state-society networks). These three types of networks should also enable change team members to make their case in favour of reform at the right time and place during the reform process.

Finally, it should be noted that it is extremely difficult to create and empower a change team as part of an effort external to the government in power. This is due to the fact that creating and using a change team is a political decision in nature, and therefore needs the consent and political backing of senior level decision-makers if it is to become an effective strategy. This thesis has pointed to the unsuccessful bids for reform made by technocratic teams that did not count or lost political backing. Under these circumstances, regardless of their mix of skills, change teams would only be capable of contributing with knowledge and information to the reform process, but would rarely be able to define the reform's agenda. In view of this, efforts geared at supporting health reform should focus on locating already existing groups of policy makers within the state and supporting them with training and funding in order to prepare them to lead and promote the health reform.

### **9.5 Agenda for Further Research**

The conceptual framework used in this thesis was very helpful in identifying key aspects determining governments' capacity to pursue health reforms and passing judgements on them. It also provided a prism through which to understand the complex political dynamics that take place at each stage of health reform processes. By the same token, the analysis in this thesis has shed light into further lines of research that would enrich the knowledge on the political economy of health sector reform.

Owing to the thesis' interest in the state's capacity to pursue its reform initiative, the framework focused its analysis from the vantage point of reformers within it. As a result, it is

biased in favour of these reformers' policy preferences – for instance the reformers' perceived need to prioritise efficiency – which competed at times with the principles formally embraced in the reform proposals – such as equity and expanding access. It was also beyond the scope of this thesis to validate the reforms' policy content against their stated principles. Such a goal would have required a thorough policy evaluation of the reform and would thus have given the political dimension a secondary role. This calls for a complementary analytical effort that would focus on the reforms' policy content and its “fit” to the needs and capacities of the health systems attempting to be reformed.

Placing the vantage point of the analysis on health change teams rendered other actors less visible. These other actors' own experience of the reform process, however central, was only present inasmuch as they made themselves visible to the change team. There are as many accounts of a social phenomenon as there are actors that witness and/or participate in it. The health reform processes analysed here would have been presented rather differently, had the focus of analysis been placed on provider groups facing the imminent implementation of a reform they opposed, for instance. Yet a third account would stem from average citizens, the intended beneficiaries of these reforms, whose awareness of the policy debate around the options to transform their health system is very fickle. However, the complexity of assigning equal relevance to these different experiences called for schematisation. Instead, this thesis' account of the politics of health reform calls for analytical comparison with other studies in the field that have focused on alternative perspectives of the same process, such as the issue of people's participation, or the perception of provider groups of health reforms, and their reaction to it.

The analytical framework in this thesis aimed at furthering knowledge of the determinants of governments' capacity to pursue health reforms, and to do so it placed the emphasis on their management of politics as a central aspect. However, other elements are also important in determining the state's capacity to bring about policy change and therefore ought to be explored. Such is the case of a state's institutional capacity – both managerial and organisational – to both pursue and absorb change. Accompanying this thesis' results with other in-depth studies on these aspects would render a more holistic perspective of the challenges behind implementing health reforms.

Other lines of research should also take relevance in future scholarly work. Perhaps the central question that arises from this thesis is that related to the transformation of the old providers in the health sector, such as the institutes of social security and the ministries of health. It was argued that change teams were effective in breaking resistance to change from vested interests in areas susceptible to be transformed by changes in rules and regulations and resource re-allocation. However, these teams encountered insurmountable obstacles when attempting to trigger changes that touched the interests of state employees in whose hands rested their implementation. This does not detract from the value of the conceptual framework *per se*, but does call for further research. In particular, it suggests that the underlying issue of labour relations between the state and its employees – both its bureaucracy and the health care provider groups – deserves more exploration when addressing the prospects of consolidating health reforms in the future.

## **9.6 Contribution to Knowledge and Policy Making**

This thesis had two objectives. First, to contribute to existing knowledge in the health policy field by furthering the analysis and explanation of the political dimension of health reforms; and second, to produce and test an analytical framework that could be used as a policy tool to support policy analysis and decision-making in health reforms.

Recent comparative research on the experience of different countries in pursuing state reform demonstrates that political leadership alone was insufficient to obtain positive results. Instead, it points to the need for policy-makers with a reform agenda to act. In other words, to make strategic decisions related to managing opposition to change and building support around reforms (Graham and Grindle, 1999; Batley, 1999).

This thesis endorses this stand by drawing attention to the political dimensions in policy decision-making around reforms, and applying this perspective to the field of health policy. It also shares the view of other studies, that the group of policy-makers in charge of the reform – the change team – can make these strategic decisions and pursue them (Graham and Grindle, 1999; Batley, 1999). This thesis thus provided an assessment of the use and prospects of change teams in health reforms by looking into their comparative advantages and disadvantages in bringing about health policy change.



Graham and Grindle (1999) also call for the need to have reformers develop the analytical skills enabling them to assess the opportunity of policy change, and the rules of the game of the political dynamics around it – among others. This thesis contributed to this effort by proposing and testing an analytical framework that may serve as a policy tool to support decision-makers in their quest to understand and better manage the political dimension of their health reform initiatives. In other words, it proposes this framework as a policy tool aimed at the rapid assessment of the determinants of the political feasibility of health reforms. In doing so, it hopes to help policy-makers interested in health reforms to understand how and why they are incorporated into the public policy agenda, and how their policy content is subject to changes during the interaction between reformers and interest groups acting within the boundaries of the political context.

Finally, the thesis offered further empirical data on health reform experiences in middle-income countries in the Latin American Region by looking at the cases of Mexico and Colombia. In so doing, the study lays the groundwork for further comparative analysis in other middle-income countries in Latin America and other regions - such as the Middle East, Eastern Europe and Central Asia – which are also facing the challenge of reforming their health care systems.

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## **APPENDICES**

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## **Appendix I - Relevant Aspects of the Colombia Health Reform<sup>1</sup>**

### **I.1 Introduction**

This thesis has purposely avoided the formal evaluation of the health reform initiatives in Colombia and Mexico. However, responding to the need to give the reader some reference points with respect to the issues in debate during the reform process, this appendix presents a brief description of those elements of Colombia's health reform that were referred to in the body of the text and their evolution. The appendix includes a description of the new provider groups created as a result of the reform and their role in the new health system. This is followed by the highlights of the very complex transformation of the ISS, which remains the principal old provider in the health system. Some of the policy mechanisms formulated by the health change team to promote more efficient and quality health care delivery in the system are then discussed.

### **I. 2 The Creation of New Providers and their Impact on Coverage**

The health reform in Colombia was legislated in 1993, and its implementation stage started in 1995. The main objective of the reform was to attain universal access to equitable, efficient and quality care by the year 2001. The principal mechanism to achieve this goal was to legislate the compulsory affiliation to social security of all societal groups regardless of income or economic activity<sup>2</sup>.

Two health insurance plans were formulated in order to affiliate the population. One, the contributory health plan – the health insurance scheme for salaried workers, the strategy was to expand coverage from salaried workers to their family members. This health plan was to be funded with contribution stemming from a pay-roll tax on families' added income. As a result of the reform, this contribution increased from 6% to 12% of the family income in order to generate the resources to affiliate all members of the family. The other, the subsidised health plan, targeted the low income groups who had no formal employment. In this case, the principal sources of funding were a fraction of the contributory health plan – the solidarity mechanism that took 1 point from the contributory health plan and allocated it to

the subsidised one – and an equal amount stemming from the national budget. Other resources of funding were earmarked taxes and a fraction of the value added tax – called social VAT.

The affiliation to the health component of the social security system increased dramatically in the following years after the reform. While in 1993 only 20.6% of the total population was affiliated to social security, in December 1997 53% of the population was enrolled. The equivalent of 22 million Colombians. From this total of affiliates, 68% were enrolled to the contributory health plan, and 32% to the subsidised health plan (32%). At least 47% of those affiliated to the subsidised health plan belonged to the low income groups; and many were granted regular access to health services for the first time.

In spite of this progress, universal affiliation for the year 2001 will not be met. Among the principal difficulties in expanding coverage further, have been the problems in incorporating groups of the population who had no previous affiliation. In the case of the contributory health plan, the thrust of the expansion in coverage (53%) was achieved by enrolling the family members of affiliates. The reform has not had the same progress in affiliating the self-employed, in spite of having established compulsory affiliation by Law. A total of 87% of the affiliates to the contributory health plan, were employees, 8% pensioners, and only 5% were self-employed (Ministerio de Salud, 1998)<sup>3</sup>.

On the other hand, the reform has successfully expanded the regular provision of health services to areas that had been previously undeserved. This has been particularly the case of the subsidised health plan, who has brought access to the health component of social security for the first time to areas other than the main urban areas. As a result of the reform, coverage has increased in the majority of the territorial entities, where, since 1997, there has been investment in health infrastructure as a result of the new allocation of resources envisioned on the reform.

In spite of this progress, there remains a very high concentration of social security health services in urban areas catering for middle income groups. A total of 62% of

the social security affiliates are in the more developed regions – Antioquia, Atlántico, Cundinamarca, Santander, Valle, Bogotá region, which concentrate the tertiary care facilities, as well as the health service networks that are established around them. The problem of concentration is particularly acute in the contributory health plan, which has 74% of its affiliates in the more developed areas.

As a result of the reform, new organisations were created to articulate the funding and provision of health services. The *Entidades Promotoras de Salud* (EPS) in the contributory health plan, and the *Administradoras del Regimen Subsidiado* (ARS) in the subsidised health plan. Also, the old organisations functioning within the sector before the enactment of Law 100, 1993 were mandated to transformed themselves in order to operate along the lines of the new health system envisioned in the reform.

In 1998, there were 30 EPS in functioning within the contributory health plan: 10 were public, 1 public/private, and 15 were private – a further 4 (called CCF) were previous public/private health insurance schemes operating as private organisations and the social security institutions for state employees. The ISS was mandated to convert into an EPS and start operating as such. Since it retained most of its affiliates, it concentrated 63% of the total affiliates of the contributory health plan, with the following EPS in size lagging behind with only 6% of the total enrollees. Therefore, in spite the growth in size and number of the private EPS – which now have a total of 4.5 million affiliates -, the contributory health plan remains largely under the state control.

Within the subsidised health plan, at the end of 1997, 205 ARS had been created and were working in almost every municipality catering for 7 million affiliated poor. From the total of ARS, 19 are EPS, 27 CCF and 159 ESS. These institutions have faced the most serious challenges in consolidating the health reform, among which stand out the concentration of low income affiliates, the low levels of affiliation —with consequences for risk distribution. These elements, along with the problems in resource allocation have rendered their financial equilibrium fragile and their capacity to deliver the Basic Health Care Package weak. A case in point has been the evolution of the ESS. They have played an important role in affiliating

the very poor, particularly in remote regions; but their small scale and the dispersion of their target population has precluded them from providing adequate health services to the population – particularly in cases requiring high cost treatment (DNP, 1999).

Furthermore, there has been very uneven utilisation of health services. In 1997 population groups covered by the subsidised health plan had lower usage rates than those in the contributory health plan, and only resorted to the facilities for emergency care. This situation has been attributed the lack of promotion of EPS and ARS health facilities. But factors such as long distances, lack of accurate information on the target population - especially in rural areas - and the affiliates' low levels of education and lack of information on their rights under the new health plans have also been major factors.

Affiliation and access to health services in the contributory health plan has also been a challenge, if of a different nature. The self-employed and those working in the informal sector have been slow to join the new health plan. Again, this is partly attributed to insufficient promotion of the new health plan. However, the amount of the contribution to be made has deterred middle and low income groups who are in the informal sector from affiliating – this is particularly the case of those who are not entitled to receive a partial subsidy from the state.

### **I. 3 The Transformation of Old Providers: The Case of the ISS**

According to González and Pérez (1998), the health reform's transition period has faced its hardest challenges on the implementation of the subsidised health plan and the transformation of the ISS into an EPS within the contributory health plan. According to the health reform plan, the ISS was to undergo an in-depth transformation of its *modus operandi* in order to be able to operate by the rules of the new health care system and also to be able to compete with the new provider organisations in the contributory health plan (EPS). For this purpose, its status was formally changed to that of an industrial and commercial state enterprise, with autonomy and contracting rules equal to those of a private sector firms. It was

allowed to retain its national level coverage, but was expected to deconcentrate its activities and decentralise its functions into smaller administrative units.

The number of affiliated to the ISS rose considerably and suddenly as a result of the reform, since by law, the family members of those previously enrolled became affiliates with granted access to health care. The number of its affiliates grew from 7.3 million in 1995, to 9.3 million in 1997. However, these changes were not matched by the transformation of the ISS. The Institute resisted many aspects of the reform, and by 1998, it continued to delay the implementation of key aspects of the reform, such as the definition of the Benefits Package content, the co-payment measures, the compensation mechanisms, the separation of health service financing and provision activities, and the separation of the pensions and health service funds.

This had a series of negative impacts on the transition of the health reform and its possibilities of consolidating policy change into a new health system. On the one hand, the lack of formal limits to the package of services offered by ISS became an unfair competition strategy with the rest of the EPS, who could not offer similar services. As a result, ISS affiliates were discouraged from leaving the ISS and joining the new EPS. The only exception were the higher income groups who “opted-out” and affiliated in private EPS.

At the same time, the increase in affiliation without the accompanying limitation on the benefits package exacerbated the financial problems of the institution. This put in jeopardy the financial equilibrium of the entire contributory health plan, since it works on a common financial fund from which, in its new status as EPS, the ISS can siphon out resources to redress its financial imbalances.

The probabilities of undermining the financial viability of the contributory health plan overall, have been increasing the equal proportion as the ISS' financial problems. In 1997, the average cost of care at the ISS' facilities remained 15% higher than what had been calculated for the EPS. This was largely due to its overhead costs, which were running two-thirds higher than what was defined for the EPS due to the pay-roll costs – which could be traced back to employment benefits of its health manpower. The ISS also refused to introduce the co-payment quotas

aimed at “moderating demand” established in the new Law, which had increased systematically as a result of the reform.

#### **I. 4 Promoting Efficiency, Quality and Equity**

Efficiency, Quality and Equity were the key principles of the reform established in the new Law. The main strategy to attain them was to introduce managed competition in the affiliation of the population, and in the provision of health services. In the case of the quest for more efficient and quality care, one of the underlying mechanisms was the definition of a Basic Health Care Package (or Benefits Package). This instrument found difficulties first during legislation – where the limited health care package formulated by the change team was not approved -, and later on during implementation, where it faced technical and institutional difficulties.

The formulation of a Benefits Package was expected to work as criteria for transparent and efficient resource allocation. It could also help redress equity imbalances by establishing an objective criteria for resource allocation. Following World Bank methodological guidelines on calculating the *burden of disease*, resources were to be allocated according to this assessment and the cost-effectiveness of interventions. However, the Benefits Package defined by the change team along these guidelines was rejected in Congress, and instead, an integral package was mandated, which included prevention, promotion, diagnosis, treatment and rehabilitation along the lines of that formally offered by the ISS (Decree 1650/77). This package was to be made available to the affiliate and his/her family.

The financial constraints of the health sector impeded it to make this package available to the entire population, and so initially different packages were mandated for the two health plans: a more limited one for the subsidised health plan, and a more integral for the contributory plan. However, responding to the need to abide by the equity principles established in the Constitution, the new Law mandated that by the year 2001, both health plans should offer a single integral health package. The health change team made a last attempt at defining a minimum health care

package during the formulation of the new Law's regulation package; but the lack of sufficient information, and the political negotiations around it, made this impossible, and the definition of the health package along the lines of the services offered by the ISS in Decree 1650/1977 prevailed.

Another mechanism envisioned in the health reform to induce efficient and quality health care, was the use of market competition both in the affiliation of new enrollees, and in the provision of health services. However, the introduction of market competition has proven challenging, particularly in the subsidised health plan and in the provision of complex health care. At local level, the reduced number of health providers makes competition difficult. Furthermore, in order to ensure the financial survival of the new providers at the local level, local authorities were bound by the new Law to contract out at least 40% their services to these new enterprises, thus limiting further the potential for competition. Also, the investment and running costs required for complex health care services can only be met by public hospitals, that thus retain a monopoly in the provision of such services.

The separation of the financing and provision of services functions has also lagged behind, further hampering the possibility to introduce market competition. The most salient case is that of the old provider organisations, particularly the ISS, who continue to operate along the lines they had been operating prior to the reform. But some new providers, particularly in the subsidised health plan in some regions, are also tending to maintain the financing and provision of services together.

While unprecedented progress has been made in improving access for the poor to health services, the introduction of equity within the health care system remains the most serious challenge for the health reform. There remains a fragmented system with different providers offering different access to health care. Particularly, state employees who were affiliated prior to the reform, continue to have privileged access to public health care services. The institutions that cater for them were bounded by the new Law to adapt to the new system within a four year period (1994 –1998) by offering the same Basic Package and charging the same contributions to their affiliates, as the rest of the providers in the system. Furthermore, they were mandated to join the single fund and the compensation

process among providers that aimed to maintain a solidarity mechanism and to redress equity imbalances among social security affiliates. But these organisations have continued to offer the same comprehensive health care packages and have not joined the single fund. This has been particularly the case of the ISS, as it has been described above.

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<sup>1</sup> This section is based on Cuartas, 1998; Gonzalez and Perez, 1998; ASSALUD, 1997, Jaramillo, 1997, MOH, 1998; DNP, 1997; and ISS, 1998.

<sup>2</sup> See Law 100, 1993.

<sup>3</sup> These numbers do not include ISS affiliates.



## **Appendix II - Relevant Aspects of the Mexico Health Reform<sup>4</sup>**

### **II. 1 Introduction**

This thesis has purposely avoided the formal evaluation of the health reform initiatives in Colombia and Mexico. However, responding to the need to give the reader some reference points with respect to the issues in debate during the reform process, this appendix presents a brief description of those elements of Mexico's health reform that were referred to in the body of the text. It first gives a brief overview of the financial reengineering implemented at IMSS. The decentralisation efforts and the implementation of the Model of Integrated Health Care Services (MIAIS) follow this. A brief discussion on the new health insurance scheme is presented next, followed by the central elements on the introduction of performance incentives. Finally, a brief overview of the opt-out option policy is presented.

### **II. 2 Financial Reengineering**

Before the privatisation of IMSS' pensions fund, the Institute's long term reserves were being used to support the short-term cash needs of IMSS' health component via cross-subsidies<sup>5</sup>. Thus, with the reform of the pensions scheme, there was an urgent need to create reserves for the IMSS health care services, as well as to put in place financial mechanisms to help IMSS maintain its financial equilibrium. The need to revise IMSS financial structure also opened the opportunity to redress imbalances in resource allocation and put a limit to its discretionary use.

Among the measures that were part of the IMSS' financial reengineering were the introduction of modern actuarial systems to calculate and do follow-up activities of both investment and current expenditure, as well as the formulation of standard criteria - backed by a legal framework - for resource allocation. Simultaneously, the tripartite quota (the government-business-labour contributions to IMSS) was reconsidered in the new Social Security Law. In the new scheme put in practice in 1997, the business and labour quotas decreased, while that of government increased. This increase in government outlays redressed the negative trend in the finances of IMSS health component, and brought its internal account to positive numbers that same year, with the surplus reaching \$1,761.4 million pesos – after a deficit equivalent to \$1,146.5 million pesos in 1996.

In measure to expand its financial autonomy, in 1998, IMSS signed a management agreement (*Convenio de Fortalecimiento Financiero* or *Financial Strengthening Agreement*) with the Ministry of Finance. The agreement with the Finance Ministry was to substitute historical budget allocation, and was conditioned to IMSS on the basis of its financial performance. It established, on the one hand, IMSS' independence in financial decision related to its own budget. While in the past IMSS took autonomous decisions on its budgetary flows stemming from the employer-employee quotas, it was dependent on the government's decisions regarding its contribution to IMSS, which changed according to the country's economy's cycles and the fiscal policy adopted in response.

The *Convenio de Fortalecimiento Financiero* also gave IMSS more leeway to sign, in its turn, similar contracts with its own administrative units throughout the country. These management agreements (*Convenios de Gestion*) among IMSS different levels of care and the central level were also aimed at substituting historical budget allocation. The criteria for the formulation of the new management contracts had an emphasis on equity in budget allocation, and incorporated epidemiological and demographic indicators.

Aside from the fresh funds allocated to IMSS via the increase in the government's participation on the tripartite quota, IMSS secured a credit from the World Bank for \$700 million US dollars to solve the existing lag in health infrastructure and technology investment<sup>6</sup>. A further credit for \$25 million US dollars was directed at developing strategic projects of technical assistance to support the health reform's policy formulation and implementation<sup>7</sup>.

### **II. 3 Health Service Decentralisation**

In 1995 and 1996, IMSS established seven regions that were to function as administrative units throughout the country in order to streamline decision making among the 37 already existing delegations and the centre. In other words, an administrative figure was created to mediate between the centre and the local level. In 1998, these regions were assigned purchasing responsibilities for equipment and supply.

In 1997, these regions were further subdivided in what eventually came to be called *Decentralised Medical Areas* (AMGD). These administrative units form the axis of IMSS'

decentralisation process, since they are to become responsible for the management agreements with the centre described in the previous section<sup>8</sup>. The AMGDs are defined according to the demographic and epidemiological characteristics of their target population, as well as IMSS' local capacity to respond to its needs. Each AMGD is formed by at least one Zone General Hospital or a Regional Hospital, Sub-Zone Hospitals, Family Medicine Units, and the Community Health activities servicing its area of influence. In 1998, the totality of the 139 AMGD's were officially formed and IMSS had commitment to signing Management Agreements with all of them by 2000. But progress has been slow. In two consecutive occasions IMSS union has objected to their implementation on the grounds that it was not consulted, and later on, that it needed to adjust its own organisational design before it could proceed to operate under this new scheme. By the end of 1999, less than 7 agreements had been signed.

#### **II. 4 The New Family Medicine Model, Doctor Eligibility and other Performance Incentives**

According to the government's *Health Sector Reform Program 1995- 2000*, family doctor eligibility was to be allowed as a mechanism to promote quality care. To implement this measure, the IMSS formulated the *New Family Medicine Model* to strengthen health care services at primary level and introduce an integral approach to service delivery. It also aimed at putting incentives in place to motivate health manpower teamwork and increase the health personnel's commitment to their work.

The new health service delivery model was also aimed at increasing the resolution capacity of first-entry and primary level health units, and to strengthen referral and counter referral with the other levels. Most importantly, it envisioned establishing the ground work for the introduction of doctors' capitation payments – in the form of extra payments to their base salaries – as an incentive to better quality care. While this integrated model has been formulated in full, and 37 pilot projects were programmed to be implemented in 1999, it has faced significant delay in its implementation. The IMSS union conditioned its implementation to having all health manpower in the selected health units be eligible to the incentives program. This has put a strain on its financial viability. The project was renegotiated with the union who approved it in 1998 on the condition that the IESSS – the union's think-tank – be given the responsibility to evaluate the results of the pilot projects.

Aside from the capitation payments to be established in the long run, the new model of family medicine also envisioned a scheme of performance incentives geared at promoting efficient and quality care both at the primary level and at the hospitals. However, the operational details of this scheme at hospital level was still pending. The areas to be covered by the incentives scheme are ample and include IMSS' non-medical areas as well. Among these stand out IMSS' hospitals, research and development centres, occupational health, medical support areas and administrative areas. IMSS union has stated that it will comply with this scheme as long as it does not imply any modifications to its Collective Labour Contract. Currently, the IESSS – the union's think-tank – is in charge of studying options to develop this scheme.

## **II. 5 The Family Health Insurance**

Responding to the government's objective to expand access to health care stated in its *Health Reform Plan 1995 – 2000*, IMSS Law created a pre-paid health insurance plan (called the *Family Health Insurance*) for population groups who worked in the informal economy – and therefore were not entitled to social security -, but who had purchasing power to cover a yearly contribution to have access to IMSS health services. As opposed to the case in Colombia, this health insurance scheme was made voluntary. The regulation package specifying the target groups and their entitlements was prepared in 1996. Annual contributions per affiliate covering him/her and 4 immediate relatives – were to be equivalent to 22.4% of the annual minimum wage (approximately \$260.00 USD<sub>1998</sub> per family). This amount was to be matched by a target subsidy equivalent to 13.9% of the official minimum wage paid from public funds.

The Family Health Insurance has been criticised on the grounds that it still presents economic barriers to access to its target population both by its total cost, and by the fact that families find the one-time annual down payment difficult to meet. Furthermore a weak information and dissemination campaign and complex procedures to sign up, have not promoted its expansion, and questions remain about IMSS' capacity to absorb the potential new demand at its already saturated entry level.

## II. 6 The Opt-out Option Policy<sup>9</sup>

The opt-out option in health services is the mechanism by which the employer is made responsible for the provision of health services for his/her employees and their families. The opt-out option established in Art. 86 in IMSS Law states that employers and employees may jointly apply for the partial reimbursement of their mandatory contribution to IMSS and procure health services other than those of IMSS, as long as these offer the same interventions at similar quality standards.

Until 1999, only 2.5% of the total IMSS affiliates (approximately 200,000 employees) used alternative health service facilities in the private sector under this scheme. A total of 95% of this group work in the banking sector. Almost all the remaining ones are opt-out agreements given to companies in the northern states of Mexico, where IMSS lacked the infrastructure to meet the demands of its affiliates.

In spite of this provision in IMSS Law, the assignment of opt-out agreements remains rare, unpredictable and at the discretion of the Institute's Technical Committee. The last request for the opt-out option was granted more than a decade ago. As a result, some private companies who are unsatisfied with the quality and efficiency of IMSS' health facilities have enrolled their employees on private health insurance schemes – while at the same time continuing to pay IMSS quotas. The private sector has also proven slow in offering options for the potential demand that would consolidate if IMSS granted opt-out requests in a more systematic manner.

However, a more predictable and systematic use of the opt-out option could facilitate a public/private mix in health service delivery and could potentially help to introduce competition and market incentives to the health sector. With these ends in mind, an amendment to IMSS Law was introduced along with the pensions reform in order to change Art. 89 and make facilitate the affiliates' choice of provider. It was envisioned that the new insurance schemes could cater to risk pools of at least 100,000 to be able to operate offering comprehensive care.

However, this policy initiative proved to be politically contentious. IMSS union saw it as a precedent for the potential privatisation of IMSS it so vehemently opposes. Furthermore, the

capacity of the private sector to respond to this potential new demand remains limited with 85% of the private hospitals in Mexico being micro firms with less than 15 beds and lack of capacity to respond to complex demands. As a result, with significant pressure from IMSS union, legislators bargained out this part of the bill on the grounds that it established the precedents to the privatisation of IMSS. Notwithstanding, given that Art. 89 was not modified, reformers were aware that there remained potential to apply the opt-out option more systematically through the formulation of its accompanying regulatory package.

In light of this stalemate, a new proposal of opt-out option policy (now called integral and comprehensive contracting out of clinical services) is currently being analysed within IMSS – and the regulation package to operationalise the opt-out option was not completed or presented to the public. Under this new agreement, the financing from service provision could be done in such a way that the employer would still pay the totality of his/her quotas to the IMSS. However, IMSS would then establish agreements for the provision of comprehensive and integral health services with the newly created Health Management Organisations (HMO's) called *Health Insurance Institutions* (ISES). Second, a “risk pool” or a “risk fund” had to be generated, where a certain value should be given to each insured person according to his/her sex, age, and average expenditure in the IMSS among other variables. Third, the firm should offer an integral package of health services that would be the same in nature, kind and quantity to the one given by the IMSS and in exchange he would receive a payment. Fourth, the ISES will establish agreements with service providers, if they have a certification of the National Insurance and Bail Bonds Commission (CNSF).

In December 1999, a law amendment to modify the General Law of Mutualist Insurance Societies and Institutions, was ratified in the Senate – as it had been approved in the Lower House, to create the new ISES and a regulation package to structure its new markets. The ISES will thus be regulated as insurance companies to be supervised by the National Health Council. The new scheme has technical problems to be solved, the difficulties in meeting the financial reserves needed to operate in an unpredictable market such as health service delivery. The successful creation of an ISES market (referred to in the body of the text as new providers) along with the regulation of IMSS opt-out option would bring about a more systematic use of a public/private mix in health service delivery in Mexico. According to the reformers' assumptions, this would also generate the market competition and thus the incentives for more efficient and quality health care in Mexico.

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<sup>4</sup> The primary sources supporting this section are:

IMSS (1998) *Programa y Convenio de Fortalecimiento Financiero 1998-2000*.

IMSS, (1998) *Modelo de Medicina de Familia*. Documento para prueba.

IMSS, (1996) *Lineamientos Estratégicos 1996-2000*. México: IMSS.

IMSS, (1997) *Reglamento del Seguro de Salud para la Familia*.

<sup>5</sup> The health component of IMSS' social security services had been operating at a loss from the outset because contributions had been calculated to reflect the costs of catering for individual affiliates, but not for their families as well. Inefficient management accompanied by the impact of economic cycles, further exacerbated this situation.

<sup>6</sup> World Bank Loan # P07720, 06/30/1998

<sup>7</sup> World Bank Loan #P055061, 06/30/1998

<sup>8</sup> These units would form the basis for the separation of the financing and provision activities in the long run.

<sup>9</sup> The opt-out option has been re-labelled several times along with the details of its contents following the political dynamics around policy formulation. The initiative that is being negotiated now is called "integral contracting out of services". For clarity purposes, this thesis uses the "opt-out option name".

### Appendix III: Colombia – List of contacted persons

	Position	Institution	NR*
1.	School of Public Health	Harvard	
2.	School of Public Health	Harvard	
3.	School of Public Health	Harvard	
4.	School of Public Health	Harvard	
5.	School of Public Health	Harvard	X
6.	School of Public Health	Harvard	
7.	School of Government	Harvard	
8.	School of Government	Harvard	X
9.	Independent Consultant (Former DNP officer)		
10.	Former Minister of Health	Health Ministry	
11.	Former Senator	Liberal Party	
12.	Planning Minister	DNP	
13.	Former Vice Minister	Health Ministry	
14.	Former member of staff	Health Ministry	
15.	Former Minister of Health	Health Ministry	
16.	Former Chief of staff	Health Ministry	
17.	Former advisor to the Minister	Health Ministry	
18.	Former advisor to the Minister	Health Ministry	
19.	Director	Health Intendencia	
20.	Legislator	Conservative Party	
21.	Researcher	FES	
22.	Researcher	ASSALUD	
23.	Legislator	Liberal Party	X
24.	Director	ISS	
25.	Researcher	FESCON	
26.	Member	Ombudsman Office	
27.	Chief of Division	DNP	
28.	Officer of Health Division	DNP	
29.	Chief Social Policy Advisor	President's Office	
30.	Advisor	President's Office	X
31.	Secretary General	Health Ministry	X
32.	Member	Health Reform Program	X
33.	Member	Health Reform Program	
34.	Officer Legal Affairs Office	Health Ministry	X
35.	Superintendent	Health Superintendency	X
36.	Member	National Social Security Council	X
37.	Member	National Social Security Council	
38.	Member	National Social Security Council	X
39.	Member	National Social Security Council	
40.	Member	National Social Security Council	
41.	Member	National Social Security Council	X
42.	Member	National Social Security Council	X
43.	Member	National Social Security Council	X
44.	Member	National Social Security Council	X
45.	Member	National Social Security Council	X
46.	Officer	Finance Ministry	
47.	Former Director	Social Unit (government)	
48.	Former Vice Minister	Health Ministry	
49.	Former Secretary General	Health Ministry	



50.	Head of the Research Unit	Ministry of Health	
51.	Chief Advisor in Social Policy	Office of the President	
52.	Representant	PAHO	X
53.	Representant	USAID	X
54.	Officer	BID	
55.	Representant	World Bank	X
56.	Representant	UNDP	X
57.	Professor Masters in Hospital Administration	Universidad Javeriana	X
58.	Researcher	Fedesarrollo	
59.	Researcher	Fundacion Corona	
60.	Researcher	Fundacion Corona	X
61.	Researcher	Fundacion Corona	X
62.	Member	Social Mision	X
63.	Member	Social Mision	
64.	Member	Social Mision	X

\*NR – No response

### Appendix IV: Mexico – List of contacted persons

	Position	Institution	NR*
65.	National Price in Public Administration	(consultant)	
66.	Chief of staff	Health Ministry	
67.	Minister's staff member	Finance Ministry	
68.	Economics Professor	ITAM	
69.	Director of the Health Economy Unit	National Institute of Public Health	X
70.	Director	IMSS	
71.	Director of Administration	Interior Ministry (former IMSS)	
72.	Consultant	PRODEISA	
73.	Director of the Department of Political Science	CIDE	X
74.	Former Finance Ministry official		
75.	Member of the Planning and Infrastructure Coordination	IMSS	X
76.	Chief of Staff	Finance Under-secretary's Office	
77.	Chief of Staff	IMSS	
78.	Researcher	CIDAC	
79.	President and General Director	(Business Community)	
80.	Director of the Social Science Department	ITAM	
81.	Director of Statistics and Computing	Health Ministry	X
82.	Member of the Finance Division	IMSS	
83.	Member of the Finance Division	IMSS	
84.	Member of the Finance Division	IMSS	X
85.	Member of the Finance Division	IMSS	
86.	Member of the Finance Division	IMSS	
87.	Member of the Finance Division	IMSS	X
88.	Member of the Finance Division	IMSS	X
89.	Researcher	Funsalud	X
90.	Professor of the Economics Department	CIDE	X
91.	Member of Planning and Infrastructure Coordination	IMSS	X
92.	Party member	PAN	
93.	Party member	PRD	
94.	Planning Coordinator	IMSS	X
95.	Researcher of the Economics Division	CIDE	
96.	Acting director of the Masters in Health Economics	CIDE	
97.	Advisor	PAN	
98.	Political Attaché	British Embassy	
99.	Professor of the Political Science Division	CIDE	
100.	Chief of Staff in Economics	Upper House – Congress	
101.	Researcher Economics Department	ITAM	
102.	Member of the President's Staff	President's Office	
103.	Member of the President's Staff	President's Office	
104.	Former officer	SEDESOL (Social Devlp.	

		Ministry)	
105	Representant	PAHO/WHO	X
106	Consultant	PRODEISA	
107	Financer	Abaco (Business Community)	
108	Social Sector Specialist	World Bank	X
109	Professor Social Sc. Department	ITAM	
110	Health Programs Director	Funsalud	
111	Member of Planning and Infrastructure Coordination	IMSS (union)	
112	Consultant (health)	PAHO/WHO	X
113	Director Masters in Public Affairs	CIDE	X
114	Supporter	PRI	
115	Legislator	PRI	
116	General Director of Foreign Affairs	Health Ministry	
117	Journalist	Reforma news paper	X
118	Member of Staff	Finance Ministry	
119	Researcher	ITAM	X
120	Member of Staff (health)	President's Office	X
121	Member of Staff (health)	President's Office	X
122	Member of Staff (health)	President's Office	
123	Member of Staff (health)	President's Office	
124	Researcher	National Institute of Public Health	
125	Official of the Planning and Infrastructure Coordination	IMSS (union)	
126	Researcher	CIDAC	
127	President	Funsalud (Business Community)	
128	Representant in Mexico	BID	X
129	Member of Administrative Division	IMSS	X
130	Member of Finance Division	IMSS	
131	Member of Finance Division	IMSS	X
132	Member of Finance Division	IMSS	
133	Executive Director	Funsalud	
134	President	National Commission of Pension Funds (CON SAR)	
135	Researcher	Colegio de Mexico	X
136	Director of the Masters in Public Affairs	ITAM	
137	General Director of Social Sector	World Bank	X
138	Director of Health Services	IMSS	X
139	Adviser	CON SAR	
140	Director	USAID	X
141	Researcher	CIDAC	X
142	General Director	EDUCAL	
143	Coordinator of Health Policy Research	Funsalud	
144	Officer	Finance Ministry	
145	Officer	Finance Ministry	X
146	Officer	Finance Ministry	
147	Officer	Finance Ministry	X
148	Officer	Finance Ministry	
149	Officer	Finance Ministry	
150	Officer	Finance Ministry	
151	Officer Finance Division	IMSS	X

152	Officer Finance Division	IMSS	
153	Member Tripartite Commission	IMSS (Business)	
154	Subdirectory World Bank Project	IMSS (union)	
155	Journalist – Labour Supplement	La Jornada news paper	X

\* NR – No response

## **Appendix V - Sample Interview Guide<sup>10</sup>**

The interview starts with a very brief and general presentation of my research and explanation that the objective of my interview is to identify the constraints and opportunities for health policy reform in the country. I then point out that it is an academic interview and that the sources remain anonymous.

### **On the background of the reform initiative:**

Reasons and motivating factors for the reform.

Persons and government agencies involved at its outset.

Agencies involved. How decided?

Persons involved. How decided?

Expected products or outcomes.

Authority to pursue the reform (where the group's decisions binding or voluntary?)

Timing (what was the time horizon, why at that particular moment?).

Cost and resources involved in the reform.

Overall impressions of the most salient features and outcomes of the reform.

### **Political strategy of policy makers in charge of the reform.**

Conformation of change team (Advisory committee, task force, informal group, formal part of governmental agency, etc.)

Collaboration mechanisms among members.

Frequency of meetings. Other forms of communications.

Did the members know each other previously?

Did the members have positive experiences in prior collaborations?

What were the individual members' reputation for doing this kind of policy task?

Where there other factors, such as common professional perspectives, similar education/background, similar perspective about the role of the state and the role of reformers?

Structure of collaboration:

Who was in charge?

How were decisions made?

How formal and informal?

Where there distinct strategies for different members (policy formulation, technical assessment, policy choice, political manoeuvring)

Communication and support with other policy makers in:

Higher levels of government

Same-level counterparts in other sectors

Bureaucracy

Legislature and other institutions

How did the reformers view participation of other groups in the policy process?

An advantage (to whom, to what purpose?)

A disadvantage (to whom, to what purpose?)

Contacts and political manoeuvring with key interest groups in society.

Other means and channels to pursue coalition building in favour of reform (media, opinion leaders, academia, international advisors and lobbying with key donor and multilateral agencies).

### **The change team's benefits and costs:**

How important was this effort to those that initiated it?

How do you know? And why do you say so?

How did you view the potential benefits of this effort?

What did you see in it for you and your peers, if anything?

What potential costs, losses and pitfalls did you see?

How do you think other policy makers and other agencies viewed the potential gains and costs of the reform initiative?

### **About outcomes and towards consolidation:**

Did the reform obtain what it was supposed to obtain thus far?

Were the goals and means to obtain them clearly stated and clearly understood by all the actors involved?

Were they achieved?

Were they taken seriously?

Did the different agencies involved share a common view of what the problem was and what their collaboration was expected to achieve?

How would you rate the reform's agenda thus far? Poor, passable, good or excellent?

Why?

What would have improved the reform initiative?

Did the process occur as designed and at the envisioned time?

Were the target problems and goals addressed?

Why, why not?

What do you know and what makes you say so?

Were formulated policies implemented?

If yes, what were the primary reasons for their acceptance?

If not, why not?

What influenced the decision not to proceed in the direction recommended?

### **Overall assessment: Looking back at this effort:**

Did the reform efforts reach the target population it was aimed at?

Was the reform even necessary?

What could have been done differently to make it more effective?

What would you in your role, have done differently?

What were the biggest problems?

What were the main limitations in the political system as it stands?

What opportunities does the political system offer?

What factors were most important to whatever success was achieved?

**About the change team:**

Is the change team's approach easier or harder to formulate policy change?

Is the change team's approach easier or harder implement policy change?

What are the characteristics of the change team that makes it ideal/not ideal to pursue health reform?

What are the salient characteristics of the team's members that proved useful or a hindrance for the pursuance of the reform's agenda?

Why?

What is your assessment about the involvement of other groups and agencies in the reform process?

**Mapping the actors:**

How influential were X and Y in the process?

What other actors played an important role in supporting the reform initiative?

How powerful were they?

What was the source of their power?

What other actors played an important role in hampering the reform process?

How powerful were they?

What was the source of their power?

How was their active resistance dealt with?

**Other sources**

Who else should I speak to about this case? About the reform in general? What documents should I review?

**Final comments:**

Any other comments or suggestions regarding health reform and ways to make it feasible?

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<sup>10</sup> See Needleman et al., 1984 and Suleiman 1974.