

**Partisan Policy Paradoxes and a New Path Towards Universality?**

**Making Sense of Health Policy Reform in Mexico and Chile**

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Public health sector reforms have swept through numerous Latin American countries in the last twenty years. Following many countries' transitions to democracy, health policy reforms tended to follow the ideological recommendations of dominant economic development theories and political parties. In this regard, the experiences of Chile and Mexico present paradoxical reform experiences. After Chile's transition to democracy in 1989, politics were characterized by a center-left coalitional government with strong roots in socialism. Contrary to traditional partisan logic, however, this apparently progressive coalition advocated for the maintenance of a non-universal public health system and chose to maintain close ties with the private sector. Nearly fifteen years passed before the Chilean government moved towards a more universal, state-regulated model of healthcare. By contrast, Mexico's transition to democracy, occurring over a decade later, saw the ascendance of a center-right government to the presidency accompanied by the implementation of a revolutionary healthcare reform that extended universal public health insurance to all Mexican citizens, regardless of income level or social group.

This paper unpacks the health policy reforms undergone by Chile and Mexico during their transitions to democracy. It assesses each country's healthcare systems both before and following transition, explaining their particular health reforms as they are impacted by policy pressures created by economic, democratic, partisan political and informational variables. This analysis leads me to conclude that partisan politics alone fails to provide anything beyond superficial insight into the health policymaking process. Instead, social policymakers face diverse pressures from various segments of society and government. Most importantly, economic concerns lie at the heart of health policymaking. Governments choose health systems that promote economic stability and growth, even if that system's underlying philosophy contradicts their partisan ideology. Therefore, Mexico's health reforms are not progressive because Vicente

Fox was a leftist president; he was not. The universal social insurance provided by Mexico's health reforms were principally designed to correct elevated levels of catastrophic citizen health spending, which can cause microeconomic injury. Similarly, while Chile's Concertación government was center-left, it maintained Pinochet's heavily privatized, non-universal healthcare system in an effort to preserve economic stability and growth. While Mexico's reforms appear more "altruistic" than Chile's, the motivation behind them was economic growth; the health of Mexico's poor was simply worked into the country's long-term economic policy.

### *Exploring Healthcare Reform in Chile and Mexico*

In Chile and Mexico, three areas of health policy play major roles in determining whether or not citizens benefit from universal access to healthcare services. The first major aspect of health policy that establishes a health system's universality is the healthcare delivery structure. This variable affects the quality and equity of health services received by different segments of the population. The two major delivery structures present in Latin American health systems are defined by whether they segment the population by socioeconomic group and assign each to a particular public healthcare institution, or if they guarantee equal access to a singular healthcare provider for all segments of society (Lloyd-Sherlock, 2000:30).

The universality of the segmented model is often questioned because this system does not necessarily guarantee universal access to public health insurance. Therefore, the second crucial component of public health policy analysis is whether or not a segmented health system provides public health insurance for the poor. Within segmented systems, a lack of social insurance for the poor can institutionalize inequities in healthcare quality by basing access on savings or the ability to pay (Lloyd-Sherlock, 2000:34). Without a system of universal social insurance, citizens are forced to finance both private and public health interventions out of their own pockets, leading to

elevated levels of spending on healthcare that are catastrophic for the poor. Some countries without universal social insurance implement “social net” programs that provide targeted funds for poor families in order to compensate for a lack of public social insurance. However, these targeted programs fail to provide solutions for societal inequalities, and are easily co-opted by corporatist politicians (Kaufman & Nelson, 2004:486).

The final variable in health policy that influences the universality of healthcare systems is the relationship between the private and public health care sectors. A major trend during the 1980s was to privatize healthcare services at the national level. Advocates of private sector growth argue that privatization promotes “sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector...” (Atkinson, 1995:486). However, health policymakers concerned with universality warn that an unregulated private health sector, and especially the presence of private insurance plans that are endorsed but not controlled by the public sector, undermines the health system’s solidarity and universality (Homedes & Ugalde, 2005:92).

The above variables represent three major aspects of healthcare reform that are different in Mexico and Chile. This study seeks to explain these differences by moving beyond a superficial discussion of partisan politics. Certainly, however, the most obvious players in social policy formation are political parties and their partisan ideologies. Parties exert pressure on policymakers from the Presidency or Congress in order to guarantee the implementation of policies that are aligned with their particular ideological leanings. However, given the partisan paradox presented above, it is clear that while party politics are important in explaining policy reform, other variables influencing social policy are needed to explain Chile and Mexico’s seemingly inconsistent reform experiences. Clearly, classic political stake-holder explanations do

not provide answers since a center-right government in Mexico implemented major healthcare reforms that guaranteed social insurance to the 57% of Mexicans who were uninsured in 2000, and a center-left coalitional government with socialist roots in Chile chose to maintain strong private sector presence in Chilean public health provision.

One basic variable for understanding social policy formulation is the degree of political centralization within a government. Analysts such as Evelyne Huber argue that "...aspects of constitutional structure that disperse political power and offer multiple points of influence on the making and implementation of policy are inimical to welfare state expansion" (Huber et al, 1993:711-749). Given this argument, the concentration of political power during Pinochet's authoritarian regime helps to explain the drastic cuts to social programs as well as the expansion of the private sector in healthcare provision that took place during the 1980s. However while political centralization provides justification for the regressive nature of both Mexico and Chile's healthcare systems pre-transition, it fails to fully explain why Concertación, Chile's first democratic government in almost twenty years, maintained Pinochet's neoliberal healthcare scheme and failed to move towards a more universal healthcare system.

The second variable that offers insight into this puzzle is the strength of civil society. This variable is important as constitutional structure and political centralization do not necessarily determine the degree to which citizens participate in the democratic process. An example is the PRI's successful control of Mexican citizens' political freedom through corporatism, an undemocratic system of political control that was successfully maintained for nearly seventy years alongside Mexico's democratic governmental institutions. As with dictatorial, centralized regimes, countries with low levels of democratization resulting from authoritarian rule or corporatism are unlikely to enjoy expansive welfare states. This is due to the

weakened nature of civil society interest groups working to expand social benefit programs to the poor (Kaufman & Nelson, 2004:70). Therefore, governments lacking strong civil societies are more likely to implement, and successfully carry out, social policies that fulfill clientelistic, partisan agendas, such as the PRONASOL and Progresa programs implemented in Mexico during the late 1980s and the 1990s. However, the degree to which grass roots groups affect social policy is constrained by bureaucracy as well as the complexity of the policymaking process.

The most convincing variable in unraveling this partisan paradox involves the economic climate during which health reforms are formulated and initiated. Kurt Weyland offers a persuasive analysis of macroeconomics' role in social policy reform. He suggests that both economic stability and sustained growth places policymakers in the domain of gains and makes them risk-averse. Applying this theory to the case of Chile, Weyland argues that politicians and policymakers during Chile's transition to democracy feared implementing any expansive social reforms because the Chilean economy, and the private sector in particular, was stable and growing at a steady, sustainable rate (Weyland, 1999:70). This argument also applies to Mexico's 2000 reforms, in which President Vicente Fox advocated for sector-wide, structural reforms to the public health system. Weyland's argument places Fox in the domain of losses due to Mexico's shaky economic record during the 1990s; Fox's failure to deliver economic growth following campaign promises to create economic prosperity further explains his reform-friendly policy stance.

Weyland's theory suggests that economic concerns overshadow the process of health policy creation. When this argument is applied to Chile and Mexico, it becomes evident that the economic implications of health policy color the lens through which both traditionally liberal and

conservative politicians approach reforms to the public healthcare system and social policy in general. Ultimately, policy decisions will be based on assumptions about what is best for the economy. Any debate regarding the universality of healthcare is secondary, its influence diminished by economics' domination of the policy discussion.

The final and least-studied variable in health policy reform is the presence of international and domestic information regarding health indices and inequalities, as well as the degree to which this information is disseminated to both health and economic policy makers. While the amount of information available on this subject is limited, especially for the case of Chile, it does offer potential insight into the health policy formation process. Particularly informative is health research since the late 1990s that focuses on the economic implications of inequities in health spending and citizen health. This research presents a new avenue through which health policymakers can link economy development and universalizing healthcare policies. Due to the emergent status of developmental literature, this paper cannot adequately assess the impact research on policymaking in great depth. However it does provide venues for further study on the impact of health research on economic and social policy decision making.

#### *The Variables to be Assessed*

In order to unpack the paradoxical health policy reforms implemented in Mexico and Chile during the last 20 years, I include the policy analysis tools enumerated above as my independent variables in a comparative case-study analysis of health policy reform in Latin America. The independent variables for this study are: “party politics,” “political centralization,” “economic climate,” “strength of civil society,” and “spread of information.” Studied in conjunction, these variables reconstruct the political and economic climate of policy reform in

Mexico and Chile, lending support to the conclusion that politicians' desire for economic prosperity lies at the heart of health policymaking.

Party politics is measured by: the party in control of the presidency, the majority parties in Congress, and inter-party (i.e., whether parties are coalitional) as well as intra-party dynamics. Political concentration is defined by whether a country is constitutionally under an authoritarian regime or a true democracy, as well as the degree to which past authoritarianism affects the centralization of post-transition democracies. Strength of civil society refers to the extent of civil society participation (through lobbying, activism, etc.) in governmental decision-making processes as well as the degree to which parties employ clientelistic electoral practices. Economic climate is measured by economic growth, inflation, and unemployment, and spread of information is determined by the existence or non-existence of domestic and international research on health system performance and citizen health, as well as the degree to which their research impacts policymakers' decisions.

The dependent variable in this study is universality. Universality is defined by whether or not a public health system guarantees universal protection in health care; it is not determined by the equity of actual citizen health across societal groups. Three areas of public health policy are assessed in order to determine whether or not a system is universal. They are: "population integration," "social insurance," and the "public-private mix." Population integration refers to "...the [de jure] extent to which different groups are allowed access to every institution in the health system," and can be viewed on a continuum. At one extreme, a health system with "horizontal integration" guarantees universal healthcare coverage and identical social insurance plans to all segments of its population. At the other end of the continuum is "segmented integration," in which health systems fragment the availability of health insurance as well as

access to healthcare institutions along socio-economic lines (Lloyd-Sherlock, 2000:30).

Historically, health systems that utilize segmented integration are not considered universal.

Social insurance refers to whether or not a segmented healthcare system (this applies to both pre-reform Mexico and Chile) guarantees universal healthcare by providing public health insurance to all citizens, regardless of ability to pay. It is measured by the existence or non-existence of social insurance for all segments of society. The universality of social insurance can be further assessed by comparing the number and scope of its health interventions as well as the progressivity of its associated payment scheme (e.g., amount of money paid by the federal and state governments, as well as the individual) with those granted by social security institutions and/or the private sector. When segmented health systems offer universal health insurance for the poor and indigent that contains the same basic guarantees as other public and private health insurance schemes, the system is considered universal.

Public-private mix measures universality by assessing the different types of health services that are provided by the private and public sectors as well as the relative size of each, as determined by levels of expenditure and the percentage of the population that they serve. In particular, it assesses health systems' universality through the presence and substance of government-encouraged private insurance schemes, as well as the degree to which these private insurance schemes are regulated by the public sector. The existence of publicly-endorsed private health insurance typically endangers health systems' universality. However, universality is truly compromised when the health interventions and payment schemes provided by private insurance are unregulated by the public sector.

Mexico and Chile serve as my case studies for this analysis of healthcare reform in Latin America. They were selected due to their contrasting health reform experiences following

democratic transition as well as the seemingly paradoxical political climate in which reforms were implemented. Chile's center-left Concertación government chose to maintain the non-universal, highly privatized healthcare system created by Pinochet and his neoliberal economic advisors. Vicente Fox, a center-right President with a mandate for economic change, implemented universal healthcare reforms that required a major restructuring of the financing and delivery of public healthcare services in Mexico. While an assessment of the partisan political climate, the degree of political concentration, and the strength of civil society yield important insights into pressures confronting policymakers after democratic transition, it is the macroeconomic situation in Chile and Mexico that succeeds in explaining the partisan paradox embedded in both countries' healthcare reforms.

#### *Chile: Reform with Inequality*

Previous to the military dictatorship of Augusto Pinochet, which controlled Chile's government from the 1973 military coup until Patricio Aylwin's ascendance to the Presidency in 1989, Chile boasted one of the most progressive, generous healthcare systems in the world. It was the first country in the Western Hemisphere to establish governmental health insurance for non-military public workers in 1918, and the creation of the National Health Service in 1952 guaranteed quality health services for blue collar workers as well as health coverage for the indigent (Collins & Lear, 1995:94). Therefore, the neoliberal, market-friendly economic model of General Pinochet required a complete re-structuring and liberalization of Chile's lauded universal healthcare model. As the mixed public-private healthcare model adopted by Pinochet remained essentially unchanged both during and following Chile's transition to democracy, the non-universality of Chile's health system is presented primarily through an examination of the healthcare reforms implemented by the Pinochet regime. These reforms are then discussed in

relation to the independent variables in order to explain the market-friendly nature of healthcare in democratic Chile under a center-left government.

Augusto Pinochet catapulted himself to the head of Chile's military government in 1973 with a clear economic agenda: the dismantling of Chile's statist economic model, the opening of its domestic markets to the international marketplace, and the privatization of the economy (Vergara, 1994:238). Social programs suffered severe budget cuts (health expenditures fell by 30 percent from 1970 to 1988), taxes were cut, and a methodical re-organization of public programs transferred many public goods to the private sector (Weyland, 1999:73). Chile's public health system was also subsumed by Pinochet's neoliberal economic plan, undergoing tremendous modification following the dictator's implementation of the *Servicio Nacional de Servicios de Salud* (National System of Health Services, or SNSS). This new system, as explained by Pilar Vergara, "...aimed at reducing the state's presence and developing a private market in the health sector [and] led to the coexistence of two health systems that segmented the services provided according to a member's ability to pay" (Vergara, 1994:240). The dual public-private healthcare providers prescribed by the SNSS are FONASA, the public healthcare providing institution, and Isapres, private for-profit health institutions that offer individually negotiated insurance plans (Barrientos, 2002:446).

Pinochet's radical healthcare reforms institutionalized a segmented integration of the Chilean population, dividing it into three large groups. FONASA, responsible for the provision of a public health insurance scheme that functions very much like a traditional social security institution, provides health insurance for formally employed workers (the first segment), and supplies free primary healthcare for the indigent, uninsured, or people working in the informal sector (the second population segment) (Titelman, 1999:186). While health insurance is

compulsory for all employed citizens, the Chilean system is unique in that workers who are able to afford private insurance can elect to channel their health insurance contributions to either FONASA or an Isapre. People who choose to enroll in an Isapre constitute the third segment in the health system (Health Systems Strengthening in Latin America and the Caribbean, 2001).

Major concerns associated with the Chilean system emphasize the failure of the public sector to adequately regulate the private sector. Scholars such as Claudio Sapelli worry that the existence of two separate (public and private) sectors with different health insurance pricing schemes compromises the solidarity and universality of the system. Prior to 1990, Isapres' payment schemes were largely unregulated. This undermined the universality of Chile's health system, as Isapre insurance plans differed in cost depending on the number of people covered as well as their age and sex. In 1990 the transitional government established the Superintendency of Isapres to regulate the private health insurance market (Bertranou, 1999:25). While the Superintendency mandated that Isapre insurance include sickness benefits, maternity and child health care, preventative health care and a minimal coverage of twelve months, private health plans remained freely negotiated outside of these requirements (Barrientos, 2002:446).

As a result, during the mid 1990s an estimated 10,000 different private insurance plans existed, with 1,000 available at any given time (Jost, 1999:863-898). Not only did the benefits guaranteed by FONASA and Isapres insurance plans differ drastically; their payment schemes were also incongruent. FONASA's insurance scheme is essentially the same for all income brackets. It is financed by contributions (seven percent of wages) from salaried workers, federal government transfers, and copayments. In contrast, Isapre insurance plans are variable. If workers opt for private insurance, their seven percent contribution goes to the selected Isapre. Depending on the insurance plan that they select, this payment must be augmented four to seven

percent (Borzutzky & Oppenheim, 2006:151). Under this system, an individual's access to different health insurance plans is determined by his or her ability to pay. This unequal payment scheme, in addition to the dissimilar health benefits guaranteed by public and private insurance contracts, compromises the universality of the Chilean health system.

As the transitional Chilean government did not implement stringent standards for the Isapres' private insurance, during the 1990s these health plans became associated with "cream-skimming" and "health risk discrimination" practices. In other words, Isapres targeted wealthy customers who did not pose high, and therefore costly, health risks. Consequently, by 1999, more than 70 percent of Isapres members were under 40 years of age, and only 2 percent were 65 years of age or older (Bertranou, 1999:24). This extreme segmentation based on age, health and income forced FONASA to become the exclusive provider of medical services for the poorest segments of the Chilean population and for people with high health risks. For example, in 1996, over 80 percent of families in the two lowest income quintiles received their healthcare from FONASA (Sapelli, 2004:260). Not only is such a situation inequitable, it also deepened FONASA's fiscal burden by requiring it to provide medical services for people unable to make minimal insurance contributions or none at all. Moreover, FONASA's financial situation was further strained by patients with high health risks that demand costly treatment.

In addition to dismantling the solidarity of the Chilean healthcare system, the neoliberal ideology of Pinochet and his "Chicago Boys" economic advisors led Chile through a profound economic transformation that resulted in economic stability and lasting growth into the late 1980s. This economic makeover provided Chile's transitional government with a strong base for further economic growth (Scully, 1996:4). However, by 1989, Chilean society found itself deeply scarred and suffering from a severe "social debt" created by the Pinochet regime's

stringent economic turn-about (Weyland, 1999:69). Income distribution had become extremely inequitable, and extreme poverty was on the rise, as 40 percent of Chileans lived in poverty in 1987, and 16.8 percent were indigent (Scully, 1996:5).

Given the inequalities associated with Pinochet's semi-privatized health system, it is puzzling that the rise of a center-left coalitional government to the presidency in 1989 failed to implement universalizing health reforms. While social spending increased by 51 percent from 1990-1996, rising to 75 percent for health care, education and poverty alleviation programs, the Aylwin government did not implement health policies that would guarantee universal healthcare coverage in Chile. Aylwin's regulation of the Isapres' health insurance contracts was limited, as he sought to encourage the growth of the private healthcare providing sector in Chile (Raczynski, 2000:135). In order to understand this puzzling transition experience, the party politics of Chile's transition is assessed in relation to the Aylwin administration's regressive healthcare policy. As Chile's transitional government was constrained by the constitutional limitations created by General Pinochet prior to the 1988 plebiscite, political concentration created by the 1980 constitution is simultaneously discussed.

President Aylwin's ascendance to the Chilean presidency following the 1988 plebiscite was brought about by the popular election of a coalitional government known as *Concertación*. Concertación's major party members included the *Partido por la Democracia* (PPD), the *Partido Socialista Chileno* (PSCh), and the *Partido Demócrata Cristiano de Chile* (PDC) (Oxhorn, 1994:746). An alliance between the PSCh, a party with radical socialist origins, and the PDC, a centrist political party averse to any drastic changes in policy, was made possible by the complete restructuring of leftist Chilean parties during the period of military rule. Under Pinochet's dictatorship, the PSCh had engaged in an introspective process of ideological

reconstruction that led the party towards a social democratic inclination emphasizing democratic stability and rejecting both Marxism and Leninism (Robert, 1997:328).

Following in the footsteps of PSCh's ideological moderation was the PPD, a political offshoot of the PSCh. In contrast, the other major political party of the left, the *Partido Comunista de Chile* (PCCh), radicalized its political standing and was excluded from the Concertación coalition and Congress (Roberts, 1997:328). The political marginalization of PCCh placed the PSCh-PPD block, which had become considerably more social democratic and centrist, on the farthest-left wing of the Concertación government. This ensured freedom for the PSCh from leftist congressional pressures, either within or exterior to Concertación.

Concertación's primary political objective under Aylwin's government was to emphasize stability and compromise in Chilean politics. Following on the heels of Chile's turbulently politicized past of the 1970s, whose violently radical nature led to the installation of Pinochet's repressive regime, the coalition's ideologically diverse parties sought to maintain democratic stability and to project a united national front. Concertación worked hard to create a democratic regime that came to be known as "democracy by agreements" (Oxhorn, 1994:744). This desire to prevent political conflict and partisan polarization, combined with the ideological re-structuring of the PSCh, provides a possible explanation for the limited, non-universalizing changes made to Pinochet's semi-privatized healthcare system.

Concertación inherited a democratic regime tainted with the dictator's enduring desire for political control. The political centralization imposed by Pinochet's legacy further limited the coalition's ability to diverge from the former dictator's neoliberal economic plan. This included the expansion of the private health sector. In an attempt to preserve Chile on the path to capitalist democracy, Pinochet ensured that the 1980 Constitution allowed for nine additional Senate

members, to be chosen by various governmental bodies. It shocked no one when, upon losing the 1988 plebiscite, Pinochet publicly announced the nine unelected Senators, all of them conservative party members and Pinochet supporters (Scully, 1996:16). The appointment of these non-democratically elected senators helped Pinochet guarantee that the 1980 Constitution would limit the latitude of decision-making in the transitional government, thus safeguarding Chile's neoliberal economic order (Barrett, 1999:20). Their presence also gave rightist parties a majority in the Senate, providing veto power for any legislation not to their liking. This legislative majority further constricted Concertación's capacity to implement reforms, be they political, economic, or social, that conflicted with Pinochet's neoliberal economic model.

Given the state of the Chilean economy in 1989, it is no wonder that Pinochet so adamantly demanded a continuation of the neoliberal economic policies responsible for modernizing Chile's domestic markets. Following economic collapse and recession in 1982-1983, the Chilean economy bounced back in 1984 with growth due to an increase in the export of primary products as well as deindustrialization (Roberts, 1997:329). Thus the economic trend that confronted President Aylwin in 1989 was undeniably positive. The encouraging economic climate following Chile's transition to democracy worked in concert with both Concertación's conciliatory party politics and Chile's constitutional political centralization to promote the maintenance of a non-universal, highly privatized healthcare system following the transition to democracy.

The Concertación government already displayed centrist trends in policymaking due to its social democratic ideology as well as its desire to avoid political conflict and promote a strong Chilean democracy. However, as explained by Kurt Weiland, it was the country's soon-to-be-booming economy in 1989 that in fact limited the social policy and healthcare reforms available

to Concertación's liberal parties. The private sector was growing at a steady rate, and Isapres constituted an important source of private capital. This economic growth suggests that the PSCh was not averse to universalizing health reforms simply because of its alliance with the centrist PDC party and the presence of a conservative majority in the Senate. More important than the political constraints against reform, universalizing policies required fundamental changes, and even reductions, to the private health sector. The PSCh did not back away from universal health reforms entirely due to political pressures. Instead, *the party itself* wished to maintain, and even enhance, Pinochet's neoliberal economic model.

According to Weyland's theory, Chile's economic stability and growth throughout the late 1980s placed the center-left coalition in the domain of gains, making it risk-averse and therefore unlikely to pursue any policies that might change Chile's economic fortune (Weyland, 1999:70). Economic prosperity during the late 1980s had demoralized the revolutionary vision of the PCCh while simultaneously galvanizing the moderate sectors of the PSCh, as well as the Concertación coalition in general (Roberts, 1997:333). "...rather than rock the boat, Concertación decided to seek further improvements, especially reforms with 'prudence'" (Flisfisch, 1989:361-369). By 1993, the private sector accounted for three-quarters of all investment in Chile, a striking increase when compared to fifty percent in 1970. Economic policymakers within the Concertación coalition, persuaded by their risk-averse, domain-of-gains position, would be loath to interrupt Chile's development trajectory. Universalizing social policies may have curbed health inequalities, but they required changes to the private health sector that could scare off private investment and growth.

Therefore while public expenditures increased greatly under Concertación's watch, with public spending on social programs more than doubling and investment in public health

increasing by 179.3 percent between 1989 and 1997, this enlargement of the public sector did not signal an equally progressive shift in the relationship between the state and the private sector (Weyland, 1999:84). Concertación raised taxes slightly, placing 2% of private gross domestic product into public hands, but this risk-averse “democracy by agreements” did not reject neoliberalism (Weyland, 1999:73). Instead, it adopted a development strategy that relied on the strength of the market as well as the regulatory power of the state to produce a healthy economy and equitable asset distribution in society (Roberts, 1997:331). This shift in development policy by the PSCh is quite stark when compared to the strong statism typically associated with classical socialism’s view of the state’s developmental role. While this fundamental transition in economic and social policy ideology was encouraged by the coalition’s conciliatory political stance and the strength of rightist parties in the Senate, it was Chile’s economic prosperity post-transition that motivated Concertación to choose the economic well-being of the private sector over universalizing healthcare reforms (Roberts, 1997:330).

The political weakness of labor unions during democratic transition explains further the economic causes for Concertación’s aversion to universalizing health reforms. Prior to the Pinochet military dictatorship, political parties were central to everyday life in Chile, and society was highly politicized. In order to contain and control Chile’s government, the Pinochet regime sought to depoliticize Chilean society and destroy left-wing political parties (Silva, 2004:64). Patricio Silva explains that following transition, two major factors stymied societal repoliticization: traumatic memories of hyperpolarization, radicalization, and the collapse of democracy in the 1970s, and the negative impact of neoliberalism on community activism due to the atomization and consumerization of Chilean society (Silva, 2004:65). Due to Concertación’s

maintenance of Pinochet's privatization in economic and social policy, Chilean citizens held low expectations for state involvement in economic or social development strategies.

Labor unions also failed to regain a strong political voice immediately following Chile's transition to democracy. Under the dictatorship, Chile's extensive deindustrialization as well as Pinochet's harsh political repression of organized labor and market-oriented collective rights-prohibitive labor code had crushed the influence of unions in society and government (Roberts, 1997:332). This political weakness further enabled Concertación's centrist approach to economic and social policymaking. "The importance of labor and social policies resides in the fact that they constitute important instruments for correcting the distributional inequalities generated by capitalist development, and as such represent important indicators of democratization" (Barrett: 1999:6). Although labor unions may have pulled the PSCh back towards the left from its centrist leanings on economic and social policies, it failed to re-emerge as a strong political interest group following Chile's return to democracy.

At the same time, the political influence of the private sector became strengthened within Concertación. Limited legislatively by a right-wing majority in the Senate, President Aylwin sought the political support of parties beyond the Concertación alliance. These allies frequently included representatives of landholding groups and big business (Scully, 1996:17). The sheer political import of the private sector further cemented the coalitional government into a development trajectory that in many ways mirrored Pinochet's neoliberal strategies of the past (Roberts, 1997:333). In addition, it moved Concertación away from any policy changes that might hurt economic growth or private sector earnings, such as universalizing health reforms.

While the private sector profited from its political lobbying, the oppression of Chile's medical community under Pinochet may have diminished health researchers' impact on social

and health policy following transition. Policymakers active in Chile's 2005 healthcare reforms note the importance of domestic and international health research for the justification of universal health policies. Similarly in Mexico, research correlating the universality of health systems with economic growth gave health policymakers a voice in economic decision making. Pinochet, however, made every effort to silence health advocates in the medical community, as these individuals were likely to criticize the privatization of the Chilean economy and health system.

Therefore it was no mistake that Pinochet appointed admirals and military generals with no previous experience in health policy to be his Ministers of Health (Goic, 1979:560). In order to separate health research from the policymaking process, the dictator shut down the National Health Advisory Council, formerly a consultative council on health policy to the government. He also decreased the authority of Chile's Medical Association, which had previously provided the government with legally-endorsed policy input, by demoting it to the status of "voluntary organization" (Chanfreau, 1979:86-105). When, during the early 1980s, the Chilean Medical Association and individual doctors protested Pinochet's neoliberal changes to the healthcare system, numerous health professionals were accosted, interrogated, and internally exiled within Chile (Collins & Lear, 1995:97).

Pinochet's oppression may have diminished the Chilean medical research community's political voice during the years following Chile's transition to democracy. While limited information is available concerning the influence of health research on President Aylwin's inadequate and non-universalizing reforms to the private health sector, scholarly dialogue exists regarding President Ricardo Lagos' use of health research to promote universalizing health policies. Lagos, president of Chile from 2000 to 2006, implemented Plan AUGE (*Garantías*

*Explícitas con Acceso Universal*). AUGE universalized the Chilean health system by standardizing private and public health plans, both in terms of guaranteed health interventions and payment schemes. It also created the federal *Fondo de Comensación Solidario* (Solidarity Compensation Fund, or FCS), which is available to individuals whose health expenses exceed insurance coverage. The FCS is financed by universal premiums paid by both FONASA and Isapres (Urbina, 2005:76-77). Lagos hoped that by challenging the autonomy of the private sector, the AUGE reforms would reduce inequities in citizens' access to quality health services (Pittman, 2006:41).

According to Hernan Sandoval, chief health advisor to Lagos and former chief health advisor to past President Salvador Allende, "...scientific knowledge has been one of the basic pillars of our proposal for reform, especially the knowledge about equity" (Millbrook Memorial Fund, 2004:9). Looking to reform Chile's non-universal health system, Lagos' government officially commissioned the Chilean Health Equity Gauge (CHEG) in March of 2001 to engage in a prescriptive assessment of national inequities in health and healthcare services. The CHEG's findings utilized both domestic and international research, and its policy recommendations were incorporated into the official AUGE reform (PAHO, 2002). However given the primacy of economic policy makers and their concerns for market growth and stability during Chile's transition to democracy, it remains unclear why economic decision makers endorsed the universalizing private sector restrictions imposed by AUGE. Although the case of Chile leaves an explanatory gap between universal health policies and economic decision makers, the experience of Mexico provides insight into how research on health inequalities can forge a connection between economic policymaking and universalizing health reforms.

*Mexico: Moving Towards Universality*

Vicente Fox, a self-made man with strong connections to big business, was the candidate from the private sector during Mexico's 2000 presidential elections and subsequent transition to democracy. Previously the head of operations in Latin America for the Coca-Cola Company, Fox ran on a pro-free trade platform under partisan allegiance to an economically and socially right-wing political party, the *Partido Acción Nacional* (PAN) (Conger, 2001:61). Therefore, Fox's universalizing reforms to the Mexican health system appear at odds with both his and PAN's political ideologies. In the face of this apparent contradiction, Fox passed the *Sistema Social de Protección en Salud* (System for Social Protection in Health, or SPSS) into law in April of 2003. The decree behind this reform was fundamentally universalizing. It guaranteed public health insurance for all Mexican citizens, increased federal spending on healthcare in Mexico, and required that by 2010, all Mexican citizens receive universal financial protection in health (International Development Research Center, 2006:7).

In order to highlight the health system transformation mandated by the SPSS decree, its universalizing policies are contrasted with Mexico's previous, non-universal health system. As the relationship between the public and private sectors was not affected by SPSS, the public-private mix is not discussed in relation to Mexico (Gomez-Dantes, 1997:135). After introducing the former and present-day health system, Mexico's reform experience is deconstructed through an analysis of the economic, political, and informational pressures that led to the creation and implementation of SPSS in the face of a conservative political environment. Before the SPSS reforms, it was undeniable that the non-universal nature of the Mexican health system created inequities in citizen health. While the Mexican Constitution of 1917 guarantees the protection of health to be a fundamental right of citizens, since 1943 when the Ministry of Health and Mexican Institute for Social Security were established, neither institution attained the universality in

healthcare implied by this idealistic policy mandate (Soberón & Villagómez, 1999:35; Frenk et al, 2006:1524).

Previous to the 2003 reforms, Mexico's health system was fundamentally non-universal. It segmented the Mexican population into three groups defined by socioeconomic standing and assigned each faction to a particular care-providing institution or sector (Barraza-Llorens et al, 2002:49). The "open population," which included uninsured people employed in the informal sector as well as the indigent, received healthcare from the Ministry of Health (SSA, created in 1943) and the IMSS-Solidarity program (established in 1979), an institution designed to serve poor populations in rural areas. Before SPSS, the open population comprised forty to fifty percent of the Mexican populace (Gomez-Dantes, 1997:130). The second segment, both previous to and following reform, consists of private and public sector workers who are required by law to receive health insurance. This insurance is provided by the Mexican Social Security Institute (IMSS) and the Social Security and Services Institute for State Workers (ISSSTE). The third segment did not change in 2003; it includes those citizens with enough money to pay for private insurance plans. This group obtains its health insurance and healthcare services in the private sector.

While those employed in the formal market as well as citizens wealthy enough to purchase private insurance could enter into health contracts, previous to 2003 over 50 percent of the Mexican population was without access to any form of prepaid public health insurance. These citizens technically received their healthcare services from the SSA and IMSS-Solidarity, or other targeted poverty-alleviation programs implemented during the 1980s and 1990s, such as PRONASOL, Progresa or Oportunidades (Frenk et al, 2006:1525). However, these targeted efforts were fundamentally non-universal. They did not reach all uninsured Mexican citizens,

and their health benefits were incongruent to those provided through IMSS or ISSSTE public insurance. In 1998 over 50 percent of all health spending in Mexico was out-of-pocket due to the Mexican health system's lack of universal social insurance. In particular, the number of poverty-stricken families incurring high levels of individual spending on medical services exceeded those families in the highest income bracket with similar medical payments (Barranza-Llorens et al, 2002:49).

The 2003 SPSS reform was designed to correct the non-universal nature of population segmentation and exclusionary public insurance. It created *Seguro Popular (SP)*, a system of social insurance and financial protection in health for those Mexicans not covered by other insurance schemes, either public or private. SP is based on the same tripartite funding mechanism as IMSS and ISSSTE. This payment scheme, financed through contributions from the federal government, a co-responsible contributor, and the beneficiary, creates solidarity and shared responsibility between the state and families (Frenk et al, 2006:1529). SP differs from IMSS and ISSSTE health insurance in two ways: the co-responsible contributor is not an employer but the state itself, and beneficiary contributions are determined by a slide-scale subsidy based on the principle that no family should have to pay more than they are capable of. Families in the two lowest income deciles do not contribute fiscally; their acquisition of SP is provisional upon individual and family participation in health promotion activities (Frenk et al, 2006:1529).

As SP is available to citizens in all population segments and its payment scheme is identical to that of other public insurance institutions, it corrects the de-universalizing effect of population segmentation. SP also includes a basic package of 250 primary, secondary and high-cost tertiary-level interventions, financed by the *Fondo de Protección contra Gastos*

*Catastróficos* (Fund for Protection against Catastrophic Expenditures, FPGC) (Frenk et al, 2006:1529). The breadth of health interventions provided by SP further universalizes Mexico's health system by markedly increasing guaranteed comprehensive care. For example, under the previous *Oportunidades* program, only 13 interventions were guaranteed to beneficiaries (Frenk, 2006:957).

The election of Vicente Fox of the PAN party in 2000 represented a sea change in Mexican politics. It toppled the dictatorial PRI's seventy year control of the presidency and heralded a new era of democracy in Mexico. Fox, a decidedly rightist politician due to his big-business past and PAN membership, appears at odds with an expansion of health sector spending, especially considering the size mandated by the universalizing SPSS reforms. These reforms were further unlikely given the predominantly conservative and hostile political climate in Mexico, which contrasted greatly with Aylwin's "democracy by agreements." Fox found himself in hostile partisan company with the PRI, an ideologically centrist party, and PRD, which is left-leaning. His own party, supported by business as well as the middle and professional classes, also resented Fox because of his loosely partisan campaign for Mexico's presidency.

During Fox's presidential campaign, he focused on characterizing the 2000 elections as a choice between the PRI and democratic change, and avoided taking stances on ideological or programmatic issues (Shirk, 2005:168). This strategy garnered votes from leftist voters outside of the PAN's traditional constituent base, but it also disassociated Fox from the conventionally conservative PAN (Rubio & Purcell, 2004:17). Fox further aggravated PAN leaders by using decidedly non-partisan criterion to nominate appointees for public office. Seventy-five percent of Fox's top officials held no official PAN affiliation, and eight percent were members of other

political parties. While over half of Fox's appointees possessed some experience in the public sector, forty-six percent heralded from the private sector (Shirk, 2005:193). Given the strong private sector representation within Fox's administrative government, the state-centered, universalizing nature of the SPSS health reforms appear ideologically implausible.

Fox's blatant disregard for partisan loyalties caused a great deal of tension between the executive and legislative branches. This further undermined the probability of Congressional support for any presidential legislation, liberal or otherwise. In 2000, no political parties held a majority in the Chamber of Deputies or the Senate. In order to express their distaste for Fox, PAN representatives formed an oppositional block with the PRI to oppose executive legislation. This caused political grid-lock and significantly weakened Fox's legislative power (Shirk, 2005: 196). The political conservatism of this oppositional block further diminished the probability that it would support the large increase in public funding required by the SPSS to produce universal access to healthcare. In addition to facing impediments to political compromise and communication in the Congress, Fox's influence upon state-society relations was weak due to the disintegration of the PRI's corporatist system of political centralization and control.

The PRI's grip on Mexican society began to dissolve during the 1980s and 1990s as the party fell victim to political fall-out from its liberal economic reforms and the democratization of civil society. During this period of PRI decline, poverty alleviation programs focusing on health and education subsidies served as popular mechanisms of corporatist political control. Both PRONASOL and Progresa are examples of corporatist social programs utilized by Carlos Salinas de Gortari and Ernesto Zedillo Ponce de León, Fox's predecessors (Menocal, 2005:347-349). However, while the PRI maintained contact with society through clientelism and corporatist politics, this system was no longer viable following the 2000 elections. Therefore one of the key

challenges facing Fox, who was elected on a pro-democracy campaign platform, was to re-define state-society relations within Mexico's new democratic era (Shirk, 2005:180).

The lack of an effective communication medium between himself and Mexico's citizens represented a major disadvantage for Fox's administration. Once president, Fox faced the challenge of progressing beyond his public image as an agent of democratic change. He had to establish himself as a legitimate policymaker and democratic president that would bring Mexico into the twenty-first century (Shirk, 2005:199). Given the weakness of state-society affairs within the Fox administration, one might hypothesize that the SPSS reforms represented a new brand of corporatism designed to enfranchise poor voters to support the PAN. However, the universal nature of the SPSS reforms as well as the legislative gridlock created in Congress by both PAN and the PRI, an oppositional party, make this hypothesis highly implausible.

As with the case of Chile, Mexico's economic climate during transition offers the most plausible explanation for the SPSS reforms' universalizing intent. Fox entered the presidency on the heels of several tumultuous decades, economically speaking. The 1980s and 1990s in Mexico had been characterized by economic unreliability due to stringent liberalization policies, the debt crisis of the early 1980s, and the 1994 peso crisis. While the peso stabilized by 1997, Fox inherited a citizenry scarred by a grueling two decades-long economic transition. Between 1984 and 1998 income inequality distribution increased, as the bottom and middle forty percent of the population lost two and three percent, respectively, of their share of national income, while the top fifth gained five percent (Pastor & Wise, 2005:139).

The 2000 elections were not characterized by either economic crisis or boisterous growth rates as in Chile. However, the PRI had delayed Mexico's necessary post-crisis reforms of "microeconomic restructuring, distributional improvement, and market-supported interventions"

(Pastor & Wise, 2005:143). Hopes were high that Fox would resolve these lingering economic problems. The incomplete nature of Mexico's economic transition as well as its shaky economic history placed Fox in the domain of losses. This made him receptive to policy changes intended to heal wounds created by economic transition and move the Mexican economy forward. Fox's economic platform during his campaign certainly suggests that he entered office with a mandate for policy change. Not only had Fox promised to take on the country's deteriorating distributional inequalities and swelling social deficit, he also guaranteed seven percent growth rates upon election.

An analysis of the SPSS health reforms' economic objectives reveals a connection between the policy's intended economic effects and Mexico's post-transition development needs. Inherent within the SPSS was a policy response to one of the economic objectives listed above: distributional improvement. The SPSS's carefully planned universalization of the health system sought to improve income distribution by minimizing catastrophic health spending. Additionally the reforms sought to correct financial disequilibria in the public financing of the health system, which was fiscally inefficient (Pastor & Wise, 2005:144). According to Julio Frenk, a key designer of the SPSS reforms and Minister of Health under Vicente Fox, it was the financial nature of these health system criticisms, strengthened by the fact that they proposed solutions for distributional inequality, that prompted economic and social policymakers in the Mexican government to contemplate the economic advantages of universalizing reforms to the Mexican healthcare system (International Development Research Center, 2006:24). The SPSS reforms' focus on economic development may have eased classical partisan disagreement about health policy, displacing universal social insurance as a traditionally liberal policy and turning it into a non-partisan mechanism for economic progress.

Previous to the SPSS reforms, a common misconception was held amongst elected officials and economic policy specialists that Mexico's public health system received its financing from federal allocations. Research conducted by the National Institute of Health (INSP) and the Mexican Health Foundation (FUNSALUD) in the 1990s dispelled this belief by revealing that more than half of all health expenditures in Mexico were financed out-of-pocket. In addition, the poor bore the brunt of this personal expenditure on health (International Development Research Center, 2006: 9). Domestic research also made explicit the relationship between out-of-pocket expenditures on health and income distribution in Mexico by generating evidence that in 2000, an estimated 2-4 million households suffered from catastrophic payments for health care annually.

Catastrophic and impoverishing healthcare expenditures occur when thirty percent of a family's disposable income (defined as total income minus money spent on food) is spent on health, or when health spending pushes a family below the poverty line (Knaul et al, 2006:1832). These high levels of out-of-pocket and catastrophic spending demonstrate that the effects of illness extend beyond the physical, causing economic ruin and impoverishment for families without insurance. In addition, both domestic and international research revealed serious disequilibria in public financing for the Mexican health system. National studies demonstrated that although the uninsured constituted 50 percent of the population, they received only a third of federal financing for health previous to 2003 (International Conference on Social Insurance in Developing Countries, 2005:7).

According to Felicia Knaul, a director of research at FUNSALUD, the WHO's 2000 framework on health system performance was key to creating momentum and sustained commitment for the SPSS reforms within the Mexican government. The WHO framework, while

ranking Mexico at 51 out of 191 countries in terms of overall health system performance, also placed it at 144 out of 191 for financial protection in health (Knaul et al, 2006:1832). Knaul notes that both the timing of the report, which was released during the year prior to the 2000 elections, as well as strong corroborative domestic research findings, made it possible for the Ministry of Health to assume a proactive and economically prescriptive, rather than defensive, stance to healthcare reform in dealings with the Mexican government (International Development Research Center, 2006:21).

Mexico's reform experience, during which the universalization of healthcare became a policy vehicle for economic development and the completion of an unfinished economic transition, starkly contrasts with Chile's unwillingness to move towards healthcare universalization in the early 1990s. Certainly the economic situation of these two countries influenced their leaders' willingness to institute policy reform for economic change. In the case of Chile, it has been argued that economic prosperity following the return to democracy made Concertación leaders averse to implementing any policies that might disrupt the country's economic upswing. Therefore the universalization of Chile's health system, which would have required stringent equalizing restrictions on the practices and earnings of the private sector, was never a viable policy option. Contrastingly, in Mexico, Vicente Fox found himself in an economic situation that demanded policy changes to correct decades-long economic disequilibria and rampant income inequality. Fortunately for poor Mexican citizens, one of Fox's solutions to these systemic economic problems was the universalization of the Mexican health system.

Domestic and international research on health inequities was crucial for the SPSS reforms' political survival. While comparisons with Chile's recent AUGE reforms are limited due to a lack of information on the policy pressures created by information about health

inequalities, the similarities suggest an emergent relationship between health equity research and economic policymaking. Appearing simultaneously with development literature regarding the importance of human capital for economic development, these findings present exciting possibilities for the future of economic policy in developing countries. Further studies should assess the effectiveness of prescriptive health equity research and the utilization of human capital development theories in economic policymaking. Should they demonstrate a universalizing impact on health policy, the regressively partisan nature of public health funding for citizens may diminish. This would constitute a victory for those working to alleviate poverty and inequality.

While non-universal health systems are wide-spread in both developed and developing countries, the SPSS reforms' success presents hope for health activists concerned with the viability of universalizing health reforms in their own countries. Although a government's political climate may appear hostile to universal health policies, this study demonstrates that variables other than partisan politics exert important pressures on the health policymaking process. It unpacked the partisan policy paradoxes contained within both Mexico and Chile's reform experiences following democratic transition, and reconstructed the health policymaking process by examining the pressures exerted by political centralization, civil society, economic climate as well as domestic and international research institutions. Ultimately, this analysis leads to the conclusion that the needs and concerns of economic policymakers dominate the social policymaking process. So long as universalizing health reforms threaten a country's economic prospects, their implementation will be opposed. However the growing presence of domestic and international research institutions suggests a potential interrelationship between universalizing health reforms and economic development. Should such research prove influential in the policymaking arena, the future of universal health care could be more viable than ever imagined.

## Bibliography

- Atkinson, Sarah. 1995. "Restructuring Health Care: Tracking the Decentralization Debate." *Progress in Human Geography* 19 (December): 486-503.
- Barraza-Llorens, Mariana, Stephano Bertozzi, Eduardo Gonzalez-Pier and Juan Pablo Gutierrez. 2002. "Addressing Inequity in Health and Health Care in Mexico." *Health Affairs* 21 (May/June): 47-56.
- Barrett, Patrick S. 1999. "The Limits of Democracy: Socio-Political Compromise and Regime Change in Post-Pinochet Chile." *Studies in Comparative International Development* 34 (September): 3-36.
- Barrientos, Armando. 2002. "Health Policy in Chile: The Return of the Public Sector?" *Bulletin of Latin American Research* 21 (July): 442-459.
- Bertranou, Fabio M. 1999. "Are Market-Oriented Insurance Reforms Possible in Latin America? The Cases of Argentina, Chile and Colombia." *Health Policy* 47 (April): 19-36.
- Borzutzky, Silvia and Lois Hecht Oppenheim, eds. 2006. *After Pinochet: The Chilean Road to Democracy and the Market*. Gainesville: University Press of Florida
- Castiglioni, Rossana. 2001. "The Politics of Retrenchment: The Quandaries of Social Protection under Military Rule in Chile, 1973-1990." *Latin American Politics and Society* 43 (Winter): 37-66.
- Chanfreau, D. 1979. "Professional Ideology and the Health Care System in Chile." *International Journal of Health Services* 9: 86-105.
- Collins, Joseph and John Lear. 1995. "Chile's Free-Market Miracle: a Second Look." Oakland, California: The Institute for Food and Development Policy.
- Conger, Lucy. "Mexico's Long March to Democracy." *Current History* 100 (February): 58-64.
- Flisfisch, Angel. 1989. "La Política Como Compromiso Democrático." Santiago: FLACSO.
- Frenk, Julio. 2006. "Bridging the Divide: Global Lessons from Evidence-Based Health Policy in Mexico." *The Lancet* 368 (September): 954-961.
- Frenk, Julio et al. 2006. "Health System Reform in Mexico 1: Comprehensive Reform to Improve Health System Performance in Mexico." *The Lancet* 368 (October): 1524-1534.
- Goic, A. 1979. "La Salud en Chile: El Problema de Fondo." *Mensaje* 282: 550-572.

Gomez-Dantes, Octavio. 1997. "Health Reform and Policies for the Poor in Mexico." In *Healthcare Reform and Poverty in Latin America*, eds. Peter Lloyd-Sherlock. London: Institute of Latin American Studies.

González-Pier, Eduardo et al. 2006. "Health System Reform in Mexico 2: Priority Setting for Health Interventions in Mexico's System of Social Protection in Health." *The Lancet* 368 (November): 1608-1618.

Homedes, Núria. 2005. "Why Neoliberal Health Reforms have Failed in Latin America." *Health Policy* 71: 83-96.

Huber, Evelyne, Charles Ragin, and John Stevens. 1993. "Social Democracy, Christian Democracy, Constitutional Structure, and the Welfare State." *American Journal of Sociology* 99: 711-49.

International Conference on Social Health Insurance in Developing Countries. 2005. "Keynote Address: 'Poverty, Health and Social Protection.'" URL: <http://www.shi-conference.de/shi-conference/index.html>

International Development Research Center. 2006. "The Role of Evidence on Financial Protection in the Mexican Health Reform of 2003." URL: [http://www.idrc.ca/uploads/use r-S/11587455291Knaul\\_-\\_Mexico\\_Health\\_Reform.pdf](http://www.idrc.ca/uploads/use r-S/11587455291Knaul_-_Mexico_Health_Reform.pdf)

Jost, T. S. 1999. "Managed Care Regulation: Can We Learn from Others? The Chilean Experience." *University of Michigan Journal of Law Review* 51: 863-898.

Kaufman, Robert R. and Joan M. Nelson, eds. 2004. "Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America." Washington, D.C.: Woodrow Wilson Center Press.

Knaul, Felicia Marie et al. 2006. "Health System Reform in Mexico 4: Evidence is Good for Your Health System: Policy Reform to Remedy Catastrophic and Impoverishing Health Spending in Mexico." *The Lancet* 368 (November): 1828-1841.

Knaul, F., Arreola, H., and O. Méndez. 2005. "Protección Financiera en Salud, México 1992 a 2004." *Salud Pública Mex* 47: 430-439.

Knaul, Felicia Marie and Julio Frenk. 2005. "Health Insurance in Mexico: Achieving Universal Coverage Through Structural Reform." *Health Affairs* 24 (November/ December): 1467-1477.

Health Systems Strengthening in Latin America and the Caribbean. 2001. "Comparative Analysis of Social Insurance in Latin America and the Caribbean." URL: <http://www.lachsr.org/documents/comparativeanalysisofsocialinsuranceinlatinamericaandthecaribbean-EN.pdf>

Lloyd-Sherlock, Peter. 2000. *Healthcare Reform and Poverty in Latin America*. London: Institute of Latin American Studies.

Menocal, Alina Rocha. 2005. "Less Political and More Pro-Poor? The Evolution of Social Welfare Spending in Mexico in a Context of Democratization and Decentralization." *Nord-Süd Aktuell* 3 (December):

Millbrook Memorial Fund. 2004. "Using Health Research in Policy and Practice: Case Studies from Nine Countries." URL: [http://www.milbank.org/reports/0409Moynihan/0409\\_318\\_TEXT\\_r2.pdf](http://www.milbank.org/reports/0409Moynihan/0409_318_TEXT_r2.pdf)

Oxhorn, Philip. 1994. "Understanding Political Change after Authoritarian Rule: The Popular Sectors and Chile's New Democratic Regime." *Journal of Latin American Studies* 26 (October): 737-759.

Pan American Health Organization. 2002. "Disentangling the Pathways to Health Inequities: The Chilean Health Equity Gauge." URL: <http://www.paho.org/English/HDP/Equity-Chile.pdf>

Pastor, Manuel Jr. and Carol Wise. 2005. "The Lost Sexenio: Vicente Fox and the New Politics of Economic Reform in Mexico." *Latin American Politics and Society* 47: 135-160.

Pittman, Patricia M. 2006. "Beyond the Sound of One Hand Clapping: Experiences in Six Countries Using Health Equity Research in Policy" *Journal of Health Politics, Policy and Law* 31 (February): 33-49.

Raczynski, Dagmar. 2000. "Overcoming Poverty in Chile." In *Social Development in Latin America: the Politics of Reform*, eds. Joseph S. Tulcin and Allison M. Garland. Boulder: Lynne Rienner Publishers.

Roberts, Kenneth M. 1997. "Rethinking Economic Alternatives: Left Parties and the Articulation of Popular Demands in Chile and Peru." In *The New Politics of Inequality in Latin America*, eds. Douglas A Chalmers et al. Oxford: Oxford University Press.

Rubio, Luis and Susan Kaufman Purcell, eds. 2004. "Mexico Under Fox." Boulder: Lynne Rienner Publishers.

Sapelli, Claudio. 2004. "Risk Segmentation and Equity in the Chilean Mandatory Health Insurance System." *Social Science and Medicine* 58 (January): 259-265.

Scully, Timothy R. 1996. "Chile: the Political Underpinnings of Economic Liberalization." In *Constructing Democratic Governance: South America in the 1990s*, eds. Jorge L. Dominguez and Abraham Lowenthal. Johns Hopkins University Press.

Sepúlveda, Jaime, et al. 2006. "Health System Reform in Mexico 6: Improvement of Child Survival in Mexico: The Diagonal Approach." *Lancet* 368 (December): 2017-2027.

Shirk, David A. 2005. "Mexico's New Politics: The PAN and Democratic Change." Boulder: Lynne Rienner Publishers.

Silva, Eduardo. 2002. "Capital and the Lagos Presidency: Business as Usual?" *Bulletin of Latin American Research* 21 (July): 339-357.

Silva, Patricio. 2004. "Doing Politics in a Depoliticised Society: Social Change and Political Deactivation in Chile." *Bulletin of Latin American Research* 23 (January): 63-78.

Soberón, Fernando Solís and F. Alejandro Villagómez. 1999. *La Seguridad Social en México*. Mexico: Fondo de Cultura Económica.

Titelman, David. 1999. "Reforms to Health System Financing in Chile." *Cepal Review* 69 (December): 185-199.

Tulchin, Joseph S. and Allison M. Garland, eds. 2000. "Social Development in Latin America: The Politics of Reform." Boulder: Lynne Rienne Publishers.

Urbina, Rafael Urriola. 2005. "Health Care Financing and Equity: Public Insurance in Chile." *Cepal Review* 87 (December): 61-78.

Vergara, Pilar. 1994. "Market Economy, Social Welfare, and Democratic Consolidation in Chile." In *Democracy, Markets, and Structural Reform in Latin America: Argentina, Bolivia, Brazil, Chile, and Mexico*, eds. William C. Smith, Carlos H. Acuña, and Eduardo A. Gamarra. Boulder, Colorado: Lynne Reinner Publishers.

Weyland, Kurt. 1999. "Economic Policy in Chile's New Democracy." *Journal of Interamerican Studies and World Affairs* 41 (Fall): 67-96.

World Health Organization. 2006. "Commission on Social Determinants of Health: Bridging the Divide: Comprehensive Reform to Improve Health in Mexico." URL: [http://www.who.int/entity/social\\_determinants/resources/frenk.pdf](http://www.who.int/entity/social_determinants/resources/frenk.pdf)

