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Reform and Electoral Competition: Convergence Toward Equity in Latin American Health Sectors

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Abstract

Scholars of Latin America disagree about the effects on equity of social policy reforms of the 1980s and 1990s. Those who see negative or no effects blame reforms, while those who believe welfare regimes have become more equitable attribute the change not to reform but to democracy and left governance. I resolve this disagreement by first developing a more holistic measure of equity. With this measure, I establish a convergence toward equity in the health sectors of Brazil, Colombia, and Chile. I then process-trace to determine the causal factors behind this convergence. Paradoxically, I find that the reform period was crucial because it gave rise to an alliance between technocrats and politicians facing electoral competition who together succeeded in overturning preexisting policy legacies, paving the way for equity. Left governance was not a significant factor behind this convergence, while democracy was important but has been underspecified.

Keywords

health politics and policy, Latin American politics, social welfare programs

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In the 1980s and 1990s, Latin American nations were simultaneously democratizing, recuperating from dramatic economic crises, and influenced by neoliberal ideas. Accordingly, many pursued structural reforms of their social policy systems. Reformers shared the goals of generating greater efficiency and equity, a somewhat paradoxical pairing, in historically exclusionary and class-stratified social policy systems. Scholars of the reform period have claimed that these social policy reforms had either no effect or a negative effect on equity.[1] More recently, other scholars have argued that Latin American welfare regimes have experienced improved equity, purportedly by moving toward more "universal" systems. Most of these scholars, however, dismiss any role for the reform period behind this shift and point to democracy and left governance as the fundamental factors behind increased equity.[2]

I attempt to resolve these competing interpretations first by developing a fuller metric of equity to compare the health sectors of Chile, Colombia, and Brazil. Moving beyond limited measures such as spending or insurance coverage alone, the metric includes formal protection, stratification, real access, and performance; components that could also be applied to other social policy sectors. Comparison with the new metric demonstrates that not only has equity in these countries' health sectors grown, but there is also a convergence toward equity among disparate welfare performers. At least in the health sector, welfare laggards appear to have caught up with high performers, challenging theses that path dependence has led to a stasis of welfare states in relation to one another (Pribble, 2011). Using primary evidence gathered during in-country research and secondary sources, I then process-trace the politics of health policy development in each country to uncover the causal factors behind this convergence.[3] I find that the reform period was crucial to the equity observed in these health sectors today; in the reform context, an alliance between technocrats and politicians faced with electoral competition succeeded in overturning preexisting policy legacies, paving the way for equity. By contrast, I find that left governance was not a significant factor, while democracy was important but has been underspecified; electoral competition is the key variable of import.

Competing Perspectives on the Reform Period

Latin American health sectors prior to the major reforms of the 1980s and 1990s were highly inequitable. Most were divided into publicly financed and delivered systems for the poor and informal sector workers, state social security systems for formal sector workers, and small private systems composed of elite private clinics for the wealthy (which, in some countries, such as Brazil, contracted with the social security system). The stratification by class

was the result of their Bismarckian roots; like Otto van Bismarck in Germany before them, in the first half of the 20th century, Latin American political leaders used social policies such as health care and pensions as political tools, often providing distinct benefits to different groups of workers to split potentially broad opposition coalitions (Huber, 1996; Malloy, 1979; Mesa-Lago, 1978, 1989). The resulting welfare systems skewed benefits toward those with the greatest political capital and left informal and rural workers, women, the poor, and the ethnically and racially marginalized relegated to the poorly funded public sector (Ewig, 2010).

In the 1980s, dramatic economic crises tipped many of Latin America's already weak public health systems into dire fiscal straights, further reducing equity by diminishing quality and access. Simultaneously, the growing informalization of Latin American labor threatened the quality and viability of the pay-as-you-go social security health systems. The health system crisis, in turn, spurred international financial institutions, such as the World Bank and the Inter-American Development Bank, to take an interest in health reform (Homedes & Ugalde, 2005; Nelson, 1999). The reform agenda of the 1990s sought to achieve two main, sometimes competing, objectives: efficiency and equity. Market participation was the primary tool used to increase efficiency through increased private sector participation, user fees, human resources management reforms, decentralization, and separation of health care financing and provision. Equity was sought through investment in dilapidated public health infrastructures, concentration of health care resources on geographic areas with greater needs and on basic primary care, and, in some cases, public insurance for the poor. Among these reforms, the most controversial was the increased role of private providers and insurers in health systems previously dominated by the state. On this dimension, we see substantial variation among states; some embraced private sector participation, while others sought to temper it.

Scholarship on Latin American social policy can be roughly divided into work focusing on the politics and effects of reforms in particular policy sectors—such as pensions, education, or health—and those works that examine status and change of welfare regimes as a whole. Below, I review the Latin American health reform literature and the separate but interrelated literature on welfare regimes. The conclusions of this scholarship with regard to the effect of reforms on equity are contradictory and fall into three groups: sticky (no effect), stingy (lower equity), and just a stage (little effect on current trajectories).

One group of scholars sees no effect of the reform period, with some claiming that the early histories of these welfare regimes resulted in path dependence that prevents dramatic change. Those focused on the politics of

health reform largely concurred that reforms were "incomplete" or were even failures (González-Rossetti & Bossert, 2000; Homedes & Ugalde, 2005; Lloyd-Sherlock, 2000; Nelson, 2004; Weyland, 1996). Consequently, these studies predicted little change in equity across time and little variation among countries.[4] As these studies were interested in the politics of reform, none empirically measured their equity or efficiency results. Yet even studies focused on outcomes declared the reforms had little effect; Carmelo Mesa-Lago (2008) concludes that "twenty-five years of reforms have not solved the major health problems of the region and most reform goals have not materialized" (p. 355). Analyzing broader welfare regimes, Jennifer Pribble (2011) argues that Latin American welfare regimes fall into four clusters rooted in their early histories of social incorporation and have remained "sticky" despite reforms (p. 193).

A second group of scholars believes that market-oriented reforms had negative ramifications for equity in Latin American welfare regimes. These scholars, by and large, deemed that the reforms caused a shift from conservative, stratified welfare states with important state protections to stingier regimes that forced greater dependence on the market and provided lower levels of protection (Barrientos, 2004; Dion, 2010; Ewig, 2010; Haggard & Kaufman, 2008; Kaufman & Segura-Ubiergo, 2001; Segura-Ubiergo, 2007).

Other studies, however, have questioned the conclusion of negative effects, noting a recent turn to a more "inclusive and solidaristic model of social policy" (Huber & Stephens, 2012, p. 178) and greater levels of "social incorporation" (Martínez Franzoni & Sánchez-Ancochea, 2014; Pribble, 2013; Sandbrook, Edelman, Heller, & Teichman, 2007). For most of these scholars, the role of reforms in the turn toward greater equity is dismissed. Most argue instead that democracy and/or the recent turn to the political left have caused the increase in equity (Huber & Stephens, 2012; McGuire, 2010; Pribble, Huber, & Stephens, 2009; Sandbrook et al., 2007). Although Pribble (2013) also considers left-leaning ideology to be important, she specifies the dynamic of democracy more precisely: Electoral competition is essential to more universal trajectories.

These contradictions beg for explanation: Have Latin American welfare states remained sticky in the face of reform? Have they become stingier? Or, were neoliberal reforms nothing but a bump in the road on the way to greater equity once left governments and democracy swept the region? I resolve these contending arguments by making several key improvements. First, I develop a more holistic measure of equity. With this measure, I establish a clear convergence toward equity in the health sectors of Brazil, Colombia, and Chile. This is surprising because the case selection would predict divergence given that the three countries differed dramatically in terms of their

initial welfare regime cluster *and* opted for distinct reform strategies. This empirical analysis casts doubt on the first two sets of arguments: stickiness and stinginess. I then shift to the causal factors behind their convergence. The comparative historical analysis demonstrates that ideology is not a significant factor behind the convergence toward equity. Democracy is important but unspecific; electoral competition is the dynamic at work. I show that reforms designed by technocrats were crucially important in overturning preexisting policy legacies and paving the way for future equity. But these reforms were only possible when electoral competition spurred politicians to support them.

Research Design

Most previous works on reform outcomes have examined a broad range of reforms at once: pensions, health care, and in some cases, education and poverty alleviation policies. Yet there is good reason to disaggregate these policies, as reforms of different policy sectors may simultaneously move in residual and state-centered directions, with differing consequences for equity (Kaufman & Segura-Ubiergo, 2001). Health is one of three historic pillars of Latin American social policy regimes (along with pensions and education); it constitutes the greatest portion of social spending in the region; and it spans the entire population, rather than the small slice of workers that pensions have historically served.

A small-*N* comparative approach allows me to compare reforms among countries with distinct starting points, distinct reform strategies, and distinct ideological contexts.[5] Chile, Brazil, and Colombia each represent a different regional social policy "cluster." Martínez Franzoni (2008) identifies three welfare regime clusters in Latin America: high performing (Argentina and Chile), medium (Costa Rica, Brazil, Mexico, Panama, and Uruguay), and a third, weak performing cluster. Slightly differently, Pribble (2011) divides the region into four groups: high performing (Argentina, Chile, Costa Rica, Uruguay), medium high (Brazil, Mexico, and Panama), medium (Colombia, Ecuador, Paraguay, and Peru), followed by the rest. As noted above, Pribble argues that these clusters have been unchanged by neoliberal reforms.[6] Each hierarchy is based in part on equity, with indicators of social spending, social protection, and educational and health performance. Selecting one country from each of the first three clusters allows me to observe whether these three countries remain at similar levels of equity over time relative to one another in the area of health. Chile, Colombia, and Brazil also maximize variation on market participation in their health reforms, which allows me to consider the relationship between market participation and equity. In 1979, Chile dramatically shifted from a state-centered health system to one that allowed

unregulated private insurers and providers. In 2003, it carried out a reform of the reform that improved the public health system and regulated private providers, but it remains in the Latin American context highly market-oriented. Colombia, in its 1993 reform, invited an expanded role for private providers and insurers but in a regulated fashion. Brazil, by contrast, in 1990, sought to increase and equalize state provision of health care and to rein in private providers. Each of these country's major health reforms are at least a decade old, allowing me to assess the impact of reforms over the long term. Finally, to test whether left governments are a driver behind greater equity, I include left and right led governments. In Brazil and Colombia, reform legislation passed under right-wing governments while a center/left government crafted Chile's 2003 reforms.

Although displaying important variation, these three countries are similar in other ways, including strong trajectories of economic growth in the last two decades and similar levels of inequality. Table 1 summarizes the similarities and differences.

A New Metric of Equity

The primary objective of welfare policy is improved social equity. Justice and democracy require a combination of basic political liberties and the redistribution of income and services so that individuals can achieve, in Amartya Sen's words, the "capabilities" for human flourishing and full political participation (Rawls, 1971; Sen, 2000). Importantly, the distribution of resources need not be *equal* but rather *equitable*: Those in need of greater resources should receive them disproportionately. As Margaret Whitehead (1992) writes in an influential essay, inequity "refers to differences which are unnecessary and avoidable, but in addition, are considered unfair and unjust" (p. 5).

Equity is the outcome of social protection that addresses unfair and unjust differences among groups by fulfilling the needs of individuals in order that they can achieve human flourishing. Equity can be divided into four dimensions. First, a legal right to social benefits provides a juridical basis for equitable social protection. Second, resources must be distributed according to need, not according to social standing or political power. Third, the benefits must reach the intended beneficiaries. Finally, social protection must be effective in improving capabilities.

Equity provides better conceptual clarity for considering welfare regime output than other commonly used terms. "Residual" and "social democratic" refer to the *means* by which services are delivered—by the market or the state, respectively (Esping-Andersen, 1990; Titmuss, 1958). "Universal" refers to the *reach* of benefits—Universal benefits are granted to all citizens

Table 1. Key Economic Characteristics of Brazil, Colombia, and Chile.

	Brazil			Colombia			Chile		
	1990	2000	2010	1990	2000	2010	1990	2000	2010
GDP per capita	4,531.33	6,025.11	9,754.69	3,870.39	5,031.00	8,975.41	3,714.48	7,365.54	15,960.80
Inequality (Gini coefficient)	60.6	59.9 (2001)	52 (2009)	56.7 (1991)	56.8	55.3 (2004)	54	54	51 (2009)
Informal employment	41.9	46.6 (2001)	42.2 (2009)	50	60.9	59.6	33.7	33.1	30
Poverty	48	37.5 (2001)	24.8 (2009)	56.1 (1991)	54.2 (2002)	37.2	38.6	20.2	11.5 (2009)
Total social spending as % of GDP	17.63	21.15	27.06 (2009)	6.04	10.78	15.64	11.88	14.99	13.62
Health spending as % of GDP	3.59	3.90	5.21 (2009)	.93	2.02	1.91	1.76	2.84	3.87

Source. GDP per capita Geary–Khamis (G-K) method at current prices purchasing power parity (PPP)-adjusted U.S. dollars from Alan Heston, Robert Summers, and Bettina Aten, Penn World Table Version 7.1, Center for International Comparisons of Production, Income and Prices at the University of Pennsylvania, November 2012; Gini coefficient from United Nations University/World Institute for Development Economics Research (UNU/WIDER) World Income Inequality Database (WIID3.0b), September 2014. Informal employment: ILO Key Indicators of the Labor Market http://kilm.ilo.org/, except Chile 2010, is from International Labor Organization (ILO), Department of Statistics (2011). Poverty levels and social spending from Economic Commission for Latin America and the Caribbean (ECLAC), Cepalstat.
GDP = gross domestic product.

based on citizenship. Often, "social democratic" and "universal" social policy systems are more equitable, and the terms are used as synonyms for equity, but this is not always the case. Modest universalism, for example, may lead to an inequitable dualism if the better-off opt out of state systems (Esping-Andersen, 1990, p. 26).

I build on previous scholarship to develop a better measure of equity. I do not include social expenditures, a common indicator of both health policy and welfare regime change, because expenditures tell us how much is spent but not how benefits are spread among the population. Expenditures may in fact be regressive, as often is the case in Latin America where the majority of health expenditures have historically been directed at better-off sectors with access to social security health care systems (Huber, Nielson, Pribble, & Stephens, 2006). I divide the metric into four main components that reflect the above definition: formal protection, stratification, real access, and performance. Previous quantitative studies have used measures of formal protection and performance—measuring legal rights to benefits and effectiveness. But by ignoring access and stratification, they miss the core tenet of equity: distribution according to need. By considering stratification, this measure captures a primary way benefits may be skewed unjustly to some groups over others. By measuring access, it measures whether needs are really being met. Improving on previous studies, I use national household surveys to measure formal protection and access. These data are not widely used due to the difficulty of gathering the data from the individual countries, and finding comparable questions across surveys. Yet national survey data are more reliable than composite indicators from other sources and, crucially, they allow us to capture access.

A first step toward equity is to provide a legal right to benefits, or *formal protection*. In Latin American health sectors, formal protection is granted via health insurance, and thus I use health insurance coverage as my measure; in other contexts, the measure might differ.[7] However, coverage is problematic if used alone. Because health insurance in Latin America has historically been obtained through formal employment, until recently, it has only applied to formal sector workers, a problem in a region where the informal sector can account for more than 50% of the workforce. In addition, formal protection does not guarantee needs fulfillment: Insurance often has limitations, copayments may serve as a barrier, and health services themselves may not always be available.

Stratification refers to a hierarchical segmentation of rights to social benefits, usually organized by social class or occupation where some groups have a smaller menu of services and lower quality care than other groups (Esping-Andersen, 1990). Stratification is a crucial dimension of Latin

American welfare regimes but has not been incorporated into quantitative assessments (Filgueira, 1998; Mesa-Lago, 1978). Yet stratification is fundamentally inequitable, because it distributes based on power and social standing rather than need. I measure stratification by considering the proportion of dollars per capita spent on citizens in the highest echelons of a country's health system (usually the private sector, sometimes the social security sector) compared with that spent on those in the public system.

As stated above, insurance co-payments, limitations, or exclusions may result in even the formally protected lacking *real access* to care, as can manifold other factors: financial, geographic, linguistic, and familial. Access to services has not been included in most previous welfare regime studies, but it is a direct measure of needs fulfillment.[8] Access is principally restricted by ability to pay and geography. Household surveys allow me to determine the percent of those surveyed who did not seek health care due to lack of money or distance. Future research might also include waitlists, linguistic and familial barriers, for which we currently lack comparable indicators.

The fourth component is *performance*. By performance, I mean the effectiveness of policy in improving capabilities. Performance is interrelated with the other components; for example, it may also reflect distinctions in quality. It may also be affected by exogenous factors such as economic change or urbanization. I try to limit the influence of socioeconomic effects by selecting indicators closely connected to basic health care: infant mortality, number of women of reproductive age who have had a timely cervical cancer screening, and maternal mortality. Because infant and maternal mortality are almost entirely preventable, and Pap smears are easy to implement, yet cervical cancer is a leading cause of death among women in the region, these are better markers of health system performance than, for example, life expectancy, which captures more socioeconomic and biological dimensions. Because addressing unjust differences across groups is fundamental to equity, I also look at variation, where possible, in the same indicator across groups. In addition to general infant mortality, I include the infant mortality rates for Afro-descent or indigenous populations to better capture disparities by race/ethnicity. By including measures specific to women, I capture some possible gender inequities of health systems. Future work should consider more indicators of performance disparities.[9]

When comparing Brazil, Colombia, and Chile in Table 2, the value of this range of measures should be clear. The large difference between formal protection and access demonstrates the importance of measuring access, and reveals the largely symbolic nature of formal protection. Stratification captures an important unjust difference. Although perhaps of greatest interest, the performance measures may be partly attributable to socioeconomic factors;

Table 2. Health Equity, Before and After Reforms.

	Brazil before reform	Brazil after reform	Colombia before reform	Colombia after reform	Chile before second reform	Chile after reform
	1986	2008	1993	2010	2003	2009
Formal protection						
Percent population with legal right to health care	83[a]	100	11.28	86.97	91.55	97.00
Percent poor (quintiles 1,2) with legal right to health care	NA	100	4.15*	86.08*	94.58*	97.80*
Stratification						
Proportion more per capita spending in private and/or social security sector relative to public sector	NA	3.4[b]	19.7[c]	2.6[d]	2.0[e]	1.2[e]
Real access						
Percent of sick who do not seek care due to lack of money	28.52*	18.06*	NA	8.55	34.03*	27.63*[f]
Percent of sick who do not seek care due to distance	13.33	12.21	NA	12.28	17.68*	15.06*
Performance						
Infant mortality rate per 1,000 live births[g]	46.0 (1990)	17.3 (2009)	28.1 (1990)	16.2 (2009)	9.4 (2000)	7.0
Infant mortality rate, ethnically marginalized	72[h] (Afro)	62.3[i] (Afro)	120[j] (Afro)	20.73[k] (Afro)	12.8[l] (indigenous)	8.9[m] (indigenous, 2010)

(continued)

Table 2. (continued)

	Brazil before reform	Brazil after reform	Colombia before reform	Colombia after reform	Chile before second reform	Chile after reform
	1986	2008	1993	2010	2003	2009
Percent women age 15 to 65 with Pap smear in last 3 years	2[n]	78.37	59.25*,[o]	89.20*,[p]	52.12	52.63
Maternal mortality rate per 100,000 births	217 (1983)	56 (2010)	140 (1990)	92 (2010)	56 (1990)	25 (2010)

Source. (unless otherwise noted). Brazil before reform: Pesquia Nacional por Amostra de Domicílios (PNAD). 1986, Brasília: Instituto Brasileiro de Geografia e Estatística; Brazil after reform: PNAD. 2008. Brasília: Instituto Brasileiro de Geografia e Estatística. Colombia before reform: Encuesta de Caracterización Socioeconómica Nacional (CASEN). 1993. Bogotá: Departamento Nacional de Planeación; Colombia after reform: Colombia Demographic Health Survey (DHS). 2010. Calvert, Maryland: Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA) and ICF International [Producers]. ICF International [Distributor]. Chile before reform: Encuesta de Caracterización Socioeconómica Nacional (CASEN). 2003. Santiago: Ministerio de Desarollo Social. Chile after reform: Encuesta de Caracterización Socioeconómica Nacional (CASEN). 2009. Santiago: Ministerio de Desarollo Social.

a. Roemer (1991, p. 322). b. 2010 figure in Barba and Valencia (2015, p. 63). c. Author's calculations based on CASEN 1993 for beneficiaries figures, World Bank Development Indicators for population, and Barón (2007, p. 182) for spending. d. Author's calculations based on Encuesta Nacional de Calidad de Vida (ECV). 2010. Bogotá: Departamento Administrativo Nacional de Estadística beneficiary figures and Olarte and Rodriguez (2014, p. 20) for spending. e. Fondo Nacional de Salud (FONASA; 2010). f. From Encuesta de Caracterización Socioeconómica Nacional (CASEN). 2006. Santiago: Ministerio de Desarollo Social. question dropped in 2009. g. Infant Mortality and Maternal Mortality data: World Bank Development Indicators (http://databank.worldbank.org/), with years noted. h. 1987 data in Fundação Nacional de Saúde [Funasa] (2005, p. 23). i. Paixão et. al. 2010. j. Fitts (2001, p. 6). k. Glassman, Escobar, Giuffrida, and Giedion (2009, p. 30). l. Sistema de Indicadores Sociodemograficos de Poblaciones y Pueblos Indigenas: http://celade.cepal.org/redatam/PRYESP/SISPPI/ m. Instituto Nacional de Estadísticas [INE} (2012, p. 112). n. Ministerio da Saúde (1985, p. 11). o. Colombia Demographic Health Survey (DHS). 1990. Columbia, Maryland: Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA) and Institute for Resource Development/Macrointernational [Producers]. Institute for Resource Development/Macrointernational [Distributor]. p. Age range: 15 to 49.

*$p < .002$ in a two-tail independent samples difference of proportions test, pre- and post-reform.

thus, greater attention should be paid to disparities between groups on these measures, such as the infant mortality of ethnic minority groups in comparison with the national averages. In other words, access and stratification should be considered the most important components of this metric, followed by disparities among groups in performance, and finally formal protection.

Comparing the Equity of Distinct Reformers

How do Chile, Colombia, and Brazil fare in terms of equity in the health sector before and after their major reforms? Table 2 lays out each of the indicators used to measure the four components of equity and compares the change in these indicators from the closest date data were available prior to the major reform in each country with recent years.[10] For all three countries, improvements, almost across the board, indicate that these contemporary health care regimes are promoting greater health equity than prior to the reforms and are converging toward one another. These findings support the contention of scholars who have cited a turn toward greater equity.

However, this comparison of indicators runs contrary to the contention that Latin American welfare regime clusters are stable. At least when policies are disaggregated, significant change relative to one another is possible. In the health sector, Colombia has shifted regime categorizations dramatically, leaving the laggard category and becoming quite similar to or, by some measures, better than Brazil and Chile. Colombia dramatically increased its formal protection from just 11.28% of the population to 86.97%. Although it is still not as high as Brazil or Chile, the leap is dramatic. In addition, while we do not have before-reform indicators for access in Colombia, in the contemporary period, Colombia outperforms Chile and Brazil. On several performance indicators, it also does as well or better than Brazil. Meanwhile, "medium performer" Brazil outperforms "high performer" Chile on access and in one performance indicator.

These shared improvements also indicate that regardless of reform strategy—more market-oriented or more state-centric—these countries are converging toward equity in the health sector. This makes sense in formal protection, where reformers across the ideological spectrum sought greater insurance coverage but disagreed on the mechanism: the state or private providers. More surprising is the reduced stratification in Colombia and Chile, whereas Brazil is the most stratified; outcomes opposite of what one would anticipate based on the more market-driven approaches of Chile and Colombia compared with Brazil. These findings should at least lead us to revisit the scholarship that concluded that more market-oriented reforms led to stingier welfare models than more state-centric reforms.[11]

This comparison of indicators, however, does not tell us whether it is reform or other factors driving the convergence toward equity. Economic growth could be driving convergence in protection by promoting broader protections through better jobs and thus access to either social security or insurance markets. Yet as outlined in Table 1, all three countries have experienced high growth, with Chile tripling its GDP per capita since 1990, and Colombia and Brazil both more than doubling it. Based on a growth argument, Chile should be the best performer, and indeed its protection levels are very high. Yet Brazil's universal system guarantees health to all. The leap in formal protection made by Colombia is so large it could not be entirely related to growth, which is more similar to Brazil. Moreover, economic growth in all three countries has not significantly reduced the informal workforce; an increase in formal sectors workers eligible for traditional employer-based insurance has not materialized and thus cannot explain increased protection.

One might expect reductions in poverty or increases in social spending to improve access and performance. Again, the outcomes in these three countries seem unrelated when we examine Tables 1 and 2. Most surprising is that Colombia's economic access to health care is best—in spite of the highest poverty rates and least social and health spending. All three have remarkable improvements in performance. Reduced stratification is also not easily attributed to factors such as growth or poverty. Thus, economic growth, poverty levels, and social spending may be part of the story, but they do not satisfactorily explain the strong convergence toward equity. The question then turns to the political factors that may be causing convergence.

Tracing the Causes of Convergence

Careful qualitative analysis can reveal causal factors by process-tracing the complex political dynamics that led up to the changes observed in Table 2 (Collier, Brady, & Seawright, 2004). In the following comparison of the health policy histories of Chile, Colombia, and Brazil, I show that comprehensive reforms, promoted by an alliance between technocrats and politicians facing electoral competition, may have initially contributed to the decreased equity and residualism cited by other scholars, yet over the long term, these shifted the societal balance of power by weakening the power of some policy legacies and creating new ones, paving the way for equity in future years.

Numerous authors cite policy legacies as preventing radical policy change, beginning with Paul Pierson (1994). What I demonstrate is that policy legacies not only can be overcome, but reform may forge new legacies that may set countries on new policy trajectories. Policy legacies come in

various forms, but in social policy, we can point principally to interest groups and entrenched institutional structures. Organized labor and entrenched social security institutions were the primary policy legacies preventing equitable reform in Latin American health sectors. Labor was the main beneficiary of stratified health systems. Although in Latin America organized labor is essentially an elite (on average, only 22% of the workforce is long term and formal), it is militant despite its small size, and vociferously defends its social benefits (Schneider, 2013, p. 101). Thus, even in countries with weak labor movements, labor was an obstacle to comprehensive health reform. Entrenched social security institutions were another obstacle; administrators feared losing resources and political power with reforms that sought system unification.

The ability to overcome these legacies was due principally to an alliance between technocrats and politicians facing electoral competition. A defining feature of technocrats is their expertise, which they leverage to gain policy autonomy and power (Centeno & Silva, 1998, p. 2; Dargent, 2015, p. 36; Teichman, 1997, p. 32, 2001, p. 7). The complicated nature of health sectors provides an opportunity for technocrats to wield their expertise; their knowledge of health systems allows them to design policies in relative autonomy from other, less knowledgeable sectors of society, including politicians. Yet technocrats are not entirely autonomous; politicians must appoint them and provide political support for reform. Electoral competition is what motivates politicians to support comprehensive reform, rather than a piecemeal reform. Following Kitschelt and Wilkinson (2007), I define electoral competition by two elements: (a) close elections "between rival blocs identifiable to voters as alternative governing teams *ex ante* (before elections)" and (b) "a market of uncommitted voters sufficiently large to tip the balance in favor of one or the other partisan bloc" (p. 28). Substantial reforms designed by technocrats advance when politicians view reform as a potential wedge against competing parties in the pursuit of uncommitted voters. I thus build on those that have demonstrated the autonomous influence of technocrats on Latin American social policy reform but also consider how politicians shape that role (Dargent, 2015; Ewig, 2010; Haggard & Kaufman, 2008; Weyland, 2006).

The technocrat–politician alliance was unified by the fault both identified with the previous highly stratified systems that benefitted organized labor and excluded the poor. It is this alliance—not left parties—that resulted in the more equitable health care regimes displayed in Table 2. Their alliance defeated the power of labor and social security institutions, resulting in the ability to broadly re-shape health institutions into more unified structures and develop new policy legacies, some of which would promote equity. In all three cases, the left played a role, but only in Chile was it the governing party when

reform legislation was passed. The fact that Colombia's government was right wing throughout this period proves most clearly that left governance is not essential for the convergence toward equity. The reform strategy—whether market-oriented or not—also matters less for resulting equity, except where the encouragement of private business interests resulted in a new policy legacy militating against the full elimination of stratification.

Chile

In preauthoritarian Chile, the health sector was well developed with broad insurance coverage but segmented into systems of differing quality. Attempts to unify and expand coverage, however, were blocked by organized labor. In Chile beginning in the 1920s and extending through the mid-20th century, successive centrist and center-left governments used social benefits, and health benefits in particular, to woo the middle classes and then workers (Borzutzky, 2002, p. 45; Jiménez de la Jara, 2001). As a result of these extensions of benefits, Chile had the second highest social policy coverage in the region in the 1970s, reaching more than 70% of the population and almost universal coverage when health and welfare pensions were included (Mesa-Lago, 1989, p. 105). The distribution of benefits in exchange for political support, however, resulted in a stratified system that was devoted to the protection of specific groups with benefits skewed toward well-organized, urban labor and middle-class constituencies and excluding much of the rural sector (Borzutzky, 2002, p. 41). By 1952, the health sector was divided into two main insurance institutions: one for white-collar workers and civil servants and another for blue-collar workers and the poor. In addition to these, there existed a small private sector and even smaller systems for the military and police (Viveros-Long, 1986). Predictatorship attempts to streamline these programs, first by Christian Democratic Party President Eduardo Frei (1964-1970) and then by leftist Popular Unity President Salvador Allende (1970-1973), were stymied by labor unions and organized physicians (Borzutzky, 2002, p. 119; Jiménez de la Jara & Bossert, 1995, p. 161).

Organized labor's opposition to change was overcome with a dramatic market-oriented health reform carried out in the 1980s under the centralized power of General Augusto Pinochet's dictatorship (Castiglioni, 2005). The Pinochet reforms consolidated the separate white- and blue-collar health systems but added to the sector's stratification by augmenting the private system. The reforms entailed the separation of the financing and provision aspects of health care, combining existing state health systems, decentralization of public services to municipalities, and a greatly expanded role for private health insurance and provision. The reforms resulted in a significant decline in public

health expenditures, a rise in private expenditures, and a flight of the wealthiest and healthiest from the public system to the new, unregulated, private system (the Isapres), where spending per beneficiary was 4 times higher than that of the public system (Oyarzo, 1994; Viveros-Long, 1986). Chile stood out in the 1980s as a model of residualism. The private sector lavished benefits on the well-paying few while the public sector faced increased costs as it received the sick that the private sector refused to serve, and diminished financing due to the loss of its highest paying clients (Blackburn, Espinosa, & Tokman, 2004; Titelman, 2000). As Marisol Soledad Barria, Minister of Health from 2006 to 2008, described these reforms, "it was the end of the idea of solidaristic social security."[12] Although it is true that the neoliberal Pinochet reforms had a detrimental effect on cross-class solidarity, over the longer term, they also overcame major political obstacles to universality: organized labor opposition and entrenched, segmented institutions.

Following democratization from 1990 until 2010, successive center/left governments of the Coalition of Parties for Democracy (Concertación de Partidos por la Democracia [CPD]) led Chile. Throughout the 1990s, the health sector became characterized by growing health inequalities, long waits in the public health system, and changing demographics that required new health considerations.[13] Although several Concertación governments attempted to improve the public health sector, it was not until 2002, under Socialist President Ricardo Lagos, that a serious reform of the reform took place.

Health reform under President Lagos was a response to electoral competition; reform allowed the Concertación to stake out a position different from the resurgent right and attract unattached voters by responding to an overwhelming societal demand for reform. Lagos won the 1999 elections by a thin margin against a unified right in what was called "the most contested electoral event since democratic rule was restored in 1990" (Silva, 2001). The competition forced Lagos to make specific campaign promises, including reform of the health system, to capture the estimated 10% "floating voters"; among these, voters disgruntled by the "neoliberalism" that had characterized the Concertación (Garreton, 2000, pp. 80-81; Silva, 2001, p. 29). Moreover, the proposed solidaristic reform of the public health system targeted lower socioeconomic sectors, whose support for the Concertación coalition had taken a precipitous decline between 1995 and 2002 (Luna & Altman, 2011, pp. 13-15). Upon taking office in 2000, Lagos used his presidential address to promise a "profound health reform" (Lagos, 2000, p. 14). By 2002, government polls showed 90% of Chileans favored health reform, continuing to spur government action ("El Gobierno retoma el rumbo de las reformas," 2002). Health reform was believed to be a winning electoral formula given the large numbers of Chileans served by it (Pribble, 2013, pp. 48-49).

In 2002, Lagos appointed a Health Reform Commission, composed of Chilean health experts and led by former World Health Organization consultant Hernán Sandoval, to develop a reform plan for the sector.[14] Armed with expertise, in typical technocratic style, the Commission carried out its work in a highly insulated fashion and was viewed by many as having a neoliberal orientation.[15] As evidence of the Commission's autonomy, even the Ministry of Health, led by future President Michelle Bachelet, had little influence over the Commission's decisions.[16] According to labor leaders, labor was both disorganized and excluded from reform discussions.[17] By and large, technocrats in the Commission were able to advance a proposal for reform with little political or societal interference, with the exception of the new private insurers, the Isapres, which feared loss of profits if the technocrats' proposal of a universal health care fund were to pass (Ewig & Kay, 2011; Pribble, 2013, pp. 52-53). The Isapres actively opposed this aspect of the plan once the design moved to the Congress for debate.

The health fund, in its original formulation, would have held a percentage of each insured person's annual contribution, to cover the costs of high-risk patients and the poor, with the costs and benefits pooled between the private and public sectors. Ultimately, due to opposition from Isapres and right-wing parties, as well as the opposition of two influential Christian Democratic senators, only a more watered-down fund was passed, sharing risk just among private providers (Dávila, 2005; Ewig & Kay, 2011; Pribble, 2013). Despite this major failure, the 2002 reforms were successful in improving the public health system through the adoption of the Plan for Universal Access With Explicit Guarantees (Plan de Acceso Universal con Garantías Explícitas [Plan AUGE]). The Plan AUGE guaranteed all the insured—public and private—care for a list of specific medical interventions, giving patients explicit rights to services that they previously lacked. Yet the package was limited due to pressure from both the Ministry of Finance and right-wing parties that the reform not expend additional budgetary resources.[18] The Plan AUGE also sought to improve the quality of the public system through a number of strategies.

In Chile, much of the work of reducing the power of those policy legacies that traditionally support inequitable health systems was done under the dictatorship when Pinochet severely weakened labor and combined the blue- and white-collar health systems. In 2002, a center/left government motivated by electoral competition succeeded in passing reforms designed by technocrats in the president's Health Reform Commission. The reforms significantly increased access and quality in the public sector, but its proposal for risk-sharing between the public and private sectors was defeated due to private sector interests and defections by some Christian Democrats.

Colombia

Similar to Chile, Colombia's health and social security systems developed over the course of the early 20th century in a series of political struggles between the state and professionals, workers, and peasants, in which each succeeded in establishing their own separate health systems—a "fragmentation" that continues to mark Colombia's health sector (Abel, 1994; Hernández Álvarez, 2002). Yet unlike Chile, the coverage of the resulting system was minimalist. By the 1990s, the social security sector guaranteed health care to formal sector workers but never covered more than 25% of the population or 50% of salaried workers. The private sector served the highest economic strata, about 10% of the population. The state public health system served the poor—but reached barely 40% of the population. About 25% of poorest Colombians in the most isolated regions of the country had no access to health services at all (Organización Panamericana de Salud [OPS], 1995). Reform was desperately needed to increase access.

Health care reform proceeded in a political environment characterized by unprecedented electoral competition and a growing segment of unattached voters. In 1990, for the first time since the late 1840s, neither of Colombia's two traditional parties, the Liberals or Conservatives, won a majority vote in two consecutive national elections: the presidential election and election of delegates to the Constituent Assembly (Archer, 1995, p. 164). "A new type of voter, more independent of the old party ties" had emerged (Pinzón de Lewin & Röthlisberger, 2011, p. 271). One result of the Constituent Assembly was a constitutional mandate for universal health care, but one that stated health services would be provided by private entities (Article 49); a compromise between neoliberal and leftist political positions. But even this mixed mandate was unlikely to have been fulfilled under the subsequent center/right government had electoral competition not intensified. In 1991, new parties held an unprecedented 31% of Congressional seats (Moreno, 2005) and the demobilization of the M-19 revolutionary group and its subsequent organization as a leftist political party encouraged parties across the political spectrum to concern themselves with poverty and inequality. Initially, the center/right Liberal government of President César Gavaria (1990-1994) governed in coalition with both the conservative Nueva Fuerza Democrática and the leftist Alianza Democrática (AD) M-19 parties.[19]

How to fulfill the new constitutional mandate for universal health care was a subject of contention, preventing policy advances from 1991 to 1993 (Cárdenas, Miguel, & Olano, 1992; Ministerio de Salud, 1994). Moreover, in 1991, the president's attention was on pension reform. Gavaria appointed a series of Health Ministers from the AD M-19 party who advocated for

a universal insurance system with fiscal centralization and decentralized, public provision, yet their short tenures prevented much progress ("Unificación del sistema de salud," 1991). The Social Security Institute, for its part, then run by Cecilia López of a faction of the Liberal Party different from the president's, sought a reform that would achieve universal coverage by incrementally increasing its affiliates; a position supported by physicians (Ramírez, 2004, pp. 128-129; Vega-Vargas, Eslava-Castañeda, Arrubla-Sánchez, & Hernández-Álvarez, 2012). By contrast, Gavaria's top concern was increasing sectoral efficiency, a position represented by the National Department of Planning (NDP) (Gaviria Trujillo, 1993; González-Rossetti & Ramírez, 2000, p. 37; Ramírez, 2004, p. 128). From civil society, the labor movement offered a proposal for fully universal and public provision and remained militant against the reforms that the government ultimately proposed (Uribe, 2004, p. 201). Later in the process, the private insurers, represented by the Association of Integral Medicine Companies (Asociación de Empresas de Medicina Integral; Acemi), advocated a 1979 Chilean-style reform, in which unregulated private insurers would have a large stake (Vega-Vargas et al., 2012, p. 65).

It was conservative members of Congress, displeased that the pension reform proposal did not include a health reform, who pressured Gavaria to cut through the disagreements and act (González-Rossetti & Ramírez, 2000, p. 41; Vega-Vargas et al., 2012, p. 64). Similar to Lagos's strategy in Chile, in 1992, Gavaria appointed a small reform team in the NDP composed of health experts and led by the well-respected economist Juan Luis Londoño.[20] Given the widespread opposition to his proposal to privatize pensions, Gavaria mandated a simple reform—something "suave," as one team member put it.[21] Highly trained in public health and health economics and with international connections, the team gained significant autonomy as a result of its expertise (Dargent, 2015, p. 121; González-Rossetti & Ramírez, 2000, p. 4). The team drafted a reform that would have simply expanded access to the public health system, but upon presenting it to AD M-19 Health Minister Gustavo de Roux, they were pressured to provide a more comprehensive reform proposal. De Roux, however, was soon replaced by Juan Luis Londoño himself as Minister of Health when the AD M-19 left the governing coalition later that month. At the same time, Cecilia López resigned from the Social Security Institute because she disagreed with the government's approach to the reform.[22] These resignations cleared the way within the government for the president's approach, and development of the reform law then continued in the Ministry under Londoño, together with former NDP Health Director Nelcy Paredes and other team members.

According to Paredes, they examined the Chilean system but rejected it for its lack of solidarity. Although the team held a number of public fora on

the reform, labor was largely marginalized from the policy discussions (Uribe, 2004, p. 206; Vega-Vargas et al., 2012, p. 63). On December 2, 1992, Londoño presented a draft law to the Congressional Commission on Social Affairs. The draft proposed the creation of a solidarity fund to add 6 million more people to the public health system, combined with the privatization of the existing social security institute to compete with other private providers ("Salud para otros seis millones de personas," 1992). It was not left parties in Congress but rather Liberal Party leaders of the Commission—Senator and future President Alvaro Uribe Vélez and Senator María del Socorro Bustamante—who demanded that the reform go further in its universal coverage (Ministerio de Salud, 1994; N. Paredes, personal communication, October 10, 2004). They were perhaps motivated by poll numbers showing weak support for the government among the lowest socioeconomic sectors ("Bogotá: Pastrana puntea en la última encuesta," 1992). Ultimately, when the team returned with its broader, reformulated plan, the health portion of Law 100 passed on December 23, 1993, facilitated by Senator Alvaro Uribe (González-Rossetti & Ramírez, 2000, p. 50).

Although called a "Chilean reform" by critics such as Cecilia López who saw the participation of private insurers as its main thrust, Colombia's reform was a managed competition approach pairing the belief that market competition will increase efficiency with the belief that government regulation is necessary to ensure equity. The final law contained the following components: individual insurance, regulated competition between health providers, consumer choice of health insurers, state subsidies for the poorest, and a guarantee to benefits contained in a package of services determined by the state. The system allows individuals to select their insurer, but they pay their premium to a state fund that in turn pays insurers according to the risk profile of the insured, and thus risk is pooled and solidarity created. If an individual cannot pay their full premium, they may be eligible for the state subsidized regime, with a separate group of insurers and providers. The insurers are required to provide a package of services that are outlined in the Obligatory Health Plan, for which there are two separate plans, one for the contributory and one for the subsidized regime. During the reform process, a debate ensued between some private insurers, doctors, unions, left party members, and some Liberal Party members who favored identical packages for the two regimes, and the Ministry of Health and other private insurers who argued for a plan focused on basic services for the subsidized regime due to fiscal constraints. Initially, separate packages were established, but the law dictated a period of adjustment until the year 2001, by which time the entire population was to be guaranteed insurance in one of the two regimes, and the plans were to be equalized. This goal was never reached due to fiscal constraints,

although a 2008 Constitutional Court ruling pushed the two systems closer by mandating the equalization of the packages provided by the two state systems by 2012 (Ewig & Hernández, 2009). Resistance to implementation, moreover, slowed the full effects of the reform for some time (N. Paredes, personal communication, October 10, 2004; Uribe, 2004, p. 208).

In summary, a right-wing government led this reform effort, with the details left to a team of appointed health technocrats. The eventual concentration of power in the reform team allowed it to overcome the push-back of the Social Security Institute and labor. Although the reformers' proposal was initially modest, right-wing congressional members and a president facing electoral competition from the M-19 on the left and low support among lower socioeconomic sectors, pushed for a more universal reform with important elements of solidarity.

Brazil

More so than in Colombia and Chile, Brazil's health system developed in a corporatist manner, where the state used health and pension benefits as a way to appease a demanding labor movement. The result was a series of separate social security health systems, divided by sector of the economy (Malloy, 1979). In 1945, President Vargas attempted to combine the social security systems, but labor fiercely resisted (Falleti, 2010, p. 42). Under the military regime that came to power in 1964, the separate blue-collar social security systems were finally combined, and the military encouraged the private sector by allowing the new system to contract with private providers. State workers and the military still maintained their own health care systems, and the public system continued to serve the poor and informal sectors separately. In 1971, in the face of rural militancy, the Military extended social security health coverage to the rural sectors, dramatically expanding its reach (Falleti, 2010, p. 44; McGuire, 2010, p. 159; Weyland, 1996, p. 92). The rural social security system, however, was of significantly lower quality than that provided in urban areas. By the late 1980s, the Brazilian health system consisted of the social security sector, the public sector serving the poor, and the private sector. As in Chile, the military had made important strides in reducing stratification while also promoting private provision, although it did so by contracting out through the social security system rather than encouraging the separate, fully private system.

As in Chile and Colombia, experts were central to the design of Brazil's health reform. However, in Brazil, these experts were part of a social movement of health professionals that began to push the government for a publicly provided, universal, free, and decentralized health system as early as the

1960s, under the military government. Dubbed the *sanitaristas*, the movements' primary tactic was to "infiltrate" the bureaucracy, gaining top positions at first in local Secretariats of Health and later in the national Ministry of Health (Escorel et al., 2005; Falleti, 2010, p. 46; McGuire, 2010, p. 178; Weyland, 1995, p. 1702). Similar to the Chilean Health Commission members and Londoño's team, the sanitaristas used their expertise as political capital; they were public health professionals originally based in Brazilian academia (Escorel, 1999). With democratization in 1985, the left-leaning Partido do Movimento Democrático Brasileiro (PMBD) party saw electoral appeal in health sector reform. As a result, sanitaristas were hired to top posts in both the Ministry of Health and the social security institute (Instituto Nacional de Assistência Médica da Previdência Social [INAMPS]), where "a combination of party competition and state initiative propelled equity-enhancing efforts" (Weyland, 1996, p. 159).

The height of the sanitaristas' influence was during Brazil's constitutional assembly in which they successfully helped to craft a constitutional guarantee of free and universal access to health care in the 1988 Brazilian Constitution. This right was the product of political struggles that long predated the constitutional reform. Administrators of INAMPS and private health providers wanted to maintain their privileged positions of power in the existing health system and opposed the sanitaristas' objectives (Arretche, 2004, p. 166; Weyland, 1996). Trade unions "were at best lukewarm about universal health care," while unionized health care workers opposed it due to fears of cuts in salaries and had to be bought off with increased salary expenditures early on (Weyland, 1996, p. 165). Only the union of rural workers, Confederação Nacional dos Trabalhadores na Agricultura (CONTAG), was a big supporter, as the proposal promised to vastly improve rural services. It was in the constitutional assembly that the sanitaristas finally gained the upper hand to push through their vision by working closely with leftist politicians who had a strong representation on the social policy committee (Lobato & Burlandy, 2000, p. 87; Weyland, 1996, pp. 167-168).

The promulgation of the constitution was followed by the first direct elections of the president since democratization. The 1989 elections were highly competitive and marked the entry of a new party, the Worker's Party. The Worker's Party pursued a "strategy of polarization" to distinguish itself ideologically from its competitors (Hunter, 2010, p. 109). Its lead rival, conservative Fernando Collor de Mello, by contrast, led a short-lived personalist party. Collor won the election in a relatively close runoff against the Worker's Party candidate, Luiz Inácio Lula da Silva, 53% to 47% (Mainwaring, 1995, p. 372). It was under Collor's administration that the Ministry of Health was charged with drafting the laws that would implement

the new universal health system. Interested in votes through patronage rather than the programmatic reform supported by his rivals, Collor did not promote the full vision of the sanitaristas, but he also did not block the final law (Weyland, 1996, p. 171).

By now, the sanitaristas had lost many of their positions in the Ministry, but a few remained and shaped the reform laws (Weyland, 1996, p. 169). Similar to Colombia, there was conflict between those seeking fully public provision and those seeking to ensure private participation; the final result was a compromise. At this stage, private providers, having learned from the constitution writing process, were politically organized and worked arduously to defend a place for private provision. The social security institute (INAMPS), for its part, fearing a loss of power, attempted to water down the proposal for municipal decentralization. The compromise bills were presented to Congress, where the private providers influenced key Congressional members. Collor signed the main law but vetoed portions (Weyland, 1996, p. 171).

The laws that passed in 1990 created a unified, decentralized system but preserved a significant role for the private sector. The Sistema Unico de Salud (SUS) converted the previous social security health system, which had important distinctions between urban formal sector workers and rural and informal workers, into a unified, publicly funded system with the objective of providing similar quality care to all Brazilians. However, in addition to the SUS, a private, supplementary health insurance system also was allowed, in which some Brazilians also pay out of pocket for private health insurance. The fortification of this parallel private system helps to explain why the Brazilian reform, whose initial thrust was the most universal of the three countries under examination here, ultimately has some of the same characteristics as the mixed models; and in fact performs the worst in the area of stratification. As in Colombia, reform was followed by a period of significant resistance to implementation, especially as local officials, fearing a loss of patronage resources, refused to implement the reform (Weyland, 1995, 1996). However, over time, the reforms diffused at the local level (Sugiyama, 2013). Huber and Stephens point to better implementation of the reform in 1998 under Minister Serra of the center/left Partido da Social Democracia Brasileira (PSDB) government of Fernando Cardoso (2012, p. 172). Yet without the constitutional changes and the health reform laws as a legal basis, the 1998 improvements under Serra would not have had a legal basis or a policy map. Even after observing years of rocky implementation, Brazilian political scientist Marta Arretche (2000) calls the reform "the most important social policy reform decision of the decade [1980s] . . . due to its nature, importance and the extent of the decisions taken" (p. 197).

A comparison of these three countries highlights that major reforms that improved formal protection, stratification, real access, and ultimately performance were made possible by an alliance of technocrats and politicians facing electoral competition. In all three countries, technocrats—experts in public health or health economics—played a central role in designing comprehensive health reforms. These technocrats worked in insulated, appointed teams in Chile and Colombia and were comprised of individual appointees working in concert in Brazil. The technocrats used their expertise to gain significant autonomy and ultimately design and present proposals for radical health policy overhauls. But the designs would have not gone anywhere without the support of politicians. Governing parties were motivated by electoral competition to reform. In the case of Brazil, technocrats and electoral competition combined early in the democratization process, when the PMBD saw health reform as an electoral advantage and appointed sanitaristas to key posts in the Ministry of Health and INAMPS. The momentum for reform then continued into the constitution writing process, further pushed by electoral pressures. In Colombia, the right-wing governing party faced a context of pressure from "new" parties, a growing independent vote, and low polling among the least advantaged. Party members saw comprehensive health reform as essential to maintaining political support. In Chile, the Concertación had also lost support among lower socioeconomic sectors and was pushed by right-wing competition to take bolder positions.

This combination of technocratic expertise and political competition allowed reformers to overcome the opposition of labor and entrenched social security institutions where these resisted. While overturning some policy legacies, the reform processes empowered other interests. Private sector insurers and providers worked to either gain or maintain a stake in each of the reformed systems. The power of private providers in these processes explains the persistence of stratification, but under new auspices—rather than occupation, stratification today is dictated more directly by earning power. Left governance, however, was not central to the convergence toward equity. The lack of left governance altogether in Colombia proves this most clearly, and even in Brazil, the reform legislation was passed under a right-wing president. Democracy was important, however, electoral competition better specifies its most important result.

A counter-argument might be that the mechanism at work was the new constitutions in Brazil and Colombia, whereas leftist tendencies carried the day in Chile. Yet this is too simplistic. In Brazil, the coalition of technocrats and politicians that jump-started the reform preceded the constitutional reform, although the constitutional mandate certainly helped to propel the final law. In Colombia, it was not clear that the constitutional mandate would

be enforced; President Gavaria in fact tried to take a minimalist route only to be pushed to enact a more thorough reform. Further evidence of the importance of technocrats and electoral competition—not constitutions—may be provided by Mexico, where substantial improvements in equity have followed reform (Knaul et al., 2012). The 2003 reform effort was led by technocrats under a right-wing government facing high electoral competition in the newly competitive Mexican democracy but needed no constitutional change (Barba & Valencia, 2015; Lakin, 2010).

Although my case selection attempted to account for a variety of factors, the fact that all three countries converge raises the issue of lack of variation on the dependent variable. We can, however, point to other Latin American countries that have not converged toward equity. Recent evaluations of the Argentine health system point to persistent stratification and poor performance relative to its neighbors, despite similar socioeconomic indicators to the cases presented here (Belló & Becerril-Montekio, 2011; Tobar, Olaviaga, & Solano, 2011). Argentina did not enact a bold health reform (Lloyd-Sherlock, 2000, 2004). Why not? At least one of the key variables I argue are important was missing: electoral competition.[23] Peronist President Carlos Menem won the 1989 presidential elections with 47% of the vote, whereas the Radical party gained only 37%, a "lopsided victory." Support for the Peronists increased in the 1991 legislative elections while the party moved further to the center (McGuire, 1995, pp. 223-224). There was neither emergent independent vote nor concern for loss of core constituents at the time. Without competition, incentives for radical reforms to the health sector were low—especially given these would challenge labor (a Peronist base) and existing social security institutions. Encouraged by the World Bank, Menem established a health reform team in the Ministry of Finance, which produced a series of proposals between 1991 and 1995 to introduce competition into the health system, but these were partial by comparison to Brazil, Chile, and Colombia, and politicians did not push for their passage (Lloyd-Sherlock, 2000, 2004).

Conclusion

In this article, I developed a holistic measure of equity and used it to compare changes in equity before and after major health reforms in Chile, Colombia, and Brazil. The comparison demonstrated significantly improved equity after reforms, so much so that Colombia, usually considered a weak welfare regime in the Latin American context, now performs better at least in the health sector on several counts compared with high performer Chile. Brazil also made significant advances from its "medium" stature to matching that of

high performers. This convergence toward equity draws into question claims that welfare regimes in the region are "sticky" and claims that reform period had no effect or a negative effect on equity.

The comparative historical evidence suggests that the move toward equity stems not from the more recent "left turn," nor simply "democracy," but rather from an alliance between technocrats and politicians pressured by electoral competition in the reform period. This alliance successfully overcame old policy legacies—specifically labor unions and social security institutions—to dramatically restructure health systems into more unified systems with greater solidarity. In so doing, they "reset" policy legacies by abolishing or severely weakening key obstacles to change, and set a path for future, more universalistic and more equitable policies. This new path includes a broader sector of societal interests with a stake in state systems—a legacy that should reinforce the momentum toward equity. However, reforms also brought with them new forms of stratification when they favored private health insurers and providers, a factor that explains the persistence of stratification.

Finally, in terms of equity, the distinction between models of health reform in the region is less dramatic than previously supposed. Convergence toward greater equity is good news for countries that have chosen to emulate any one of these models, and demonstrates the importance of a unifying reform effort more generally.

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Notes

1. González-Rossetti and Bossert (2000), Homedes and Ugalde (2005), Lloyd-Sherlock (2000, Chapter 8), and Weyland (1996) claim no effect or failed reforms. Barrientos (2004), Dion (2010), Haggard and Kaufman (2008), Kaufman and Segura-Ubiergo (2001), and Segura-Ubiergo (2007) demonstrate lower levels of redistribution.
2. Huber and Stephens (2012), McGuire (2010), and Pribble, Huber, and Stephens (2009) all point to democracy and/or the left.
3. See Online Appendix for details and sampling frame.
4. Castiglioni (2005) did recognize important changes but did not evaluate the effects of reforms, only their politics.
5. Huber and Stephens (2012), Pribble (2013), and Martínez Franzoni and Sánchez-Ancochea (2015), among their Latin American cases, only include countries with some period of left government in recent years and, for Huber and Stephens and Martínez Franzoni and Sánchez-Ancochea, only top welfare performers.
6. Other classifications include Filgueira (1998), Mesa-Lago (1978), and Huber and Stephens (2012). I focus on Pribble and Martínez Franzoni due to their inclusion of health indicators.
7. For example, Dion (2010) and Haggard and Kaufman (2008) use insurance as an indicator of protection. In non-insurance systems, such as the British National Health Service, formal protection might be measured by those legally covered by the service.
8. Pribble (2011) measures access through the proxies of infant mortality and under five mortality rates. I measure access through the more specific reported access rate and use infant mortality as one measure of overall system performance.
9. I attempted to collect data on rural/urban and poor/wealthy disparities on other performance indicators, but these were not available across all countries.
10. An ideal measure would have numerous points in time; however, pre-reform data are extremely limited (thus narrowing the Chilean comparison to only its 2002 reform rather than the reform of 1979), and surveys with all the necessary questions are few.
11. Despite these improvements, these Latin American health systems still face enormous challenges. Space limitations prevent discussion here.
12. Author interview with Marisol Soledad Barria, staff member of the Ministry of Health under Minister Michelle Bachelet (2000-2002), May 19, 2005, Santiago, Chile. All translations from Spanish and Portuguese sources are my own.
13. Author interview with Nidia Contardo, member of the Health Reform Commission, June 10, 2005, Santiago, Chile; and author's confidential interview, member of the Health Reform Commission, June 2, 2005, Santiago, Chile.
14. These experts hailed from different parts of the Chilean bureaucracy, including the health sector, the Ministry of Finance, and some from international organizations.
15. See, for example, Duran (2001).

16. Author interview with Hernán Monasterio, Subsecretary of Health under Minister of Health, Michelle Bachelet, May 27, 2005, Santiago, Chile; and author interview with Barria, op. cit.
17. Author interview with Roberto Alarcón Gomez, National President of Confederación Nacional de los Trabajadores de la Salud (CONFENATS), May 15, 2005, Santiago, Chile; author interview with high level official of the Colegio Médico, May 31, 2005; see also Pribble (2013, p. 49).
18. Author's interviews with Contardo and confidential member of the Health Reform Commission, op. cit.
19. According to Kitschelt et al. (2010), the Colombian Party system in the 1990s leaned right, and the difference between the two main parties, the Liberals and Conservatives, was weak.
20. Initial team members included Nelcy Paredes, Health Director and then Social Development Unit Director at the National Department of Planning (NDP), Ivan Jaramillo of the Ministry of Health, Maurici Perfetti of the Ministry of Labor, and Luis Eliseo Vasquez of Institute for Social Security (González-Rossetti & Ramírez, 2000, p. 41).
21. Author interview with Nelcy Paredes, member of the health reform team, October 10, 2004, Bogotá, Colombia.
22. Author interview with Cecilia López Montaño, October 13, 2004, Bogotá, Colombia.
23. The secondary literature on the politics of Argentina's health reform is limited, providing few details on the technocrats involved.

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