A Coalition to Breakdown the Frozen Landscape: Accomplishments and Limits of Uruguayan Healthcare Reform (2005-2014)[1]

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Abstract:

The change generated in 2004 by the first electoral victory of a leftist party in Uruguay (Frente Amplio) opens a window of opportunity for the development of several structural reforms, including a health care system one, historically characterized by its institutional resistance to change. The new government was proposed to build a Sistema Nacional Integrado de Salud, which would transform the arrangements of funding, regulation and provision, strengthening State capacities as regulator – but also as provider – and seeks to articulate the actions of public and private providers.

What this article will show is that the construction of a coalition to support the reform was based among other factors in a flexible negotiation style, involving the interests of various stakeholders, even those who historically played a veto role as private providers. To that was added a conjuncture of strong sectorial crises and the window of opportunity opened by the change in government.

The review of this reform process from the Advocacy Coalition Framework approach seems to account that this broad coalition shows among its members few arrangements regarding their hard core beliefs, but instead were linked from some ideas of its political core: from one side, they share the diagnosis that the system needed some changes that transcend the mere adjustment of the existing tools; but then also existed some general consensus related to the centrality that the "mutualismo" should continue playing in the system configuration and organization.

Key words: Advocacy Coalitions, Health Care Reform, institutional change, veto points, Uruguay.

1. Introduction

The electoral victory of a leftist party in Uruguay (Frente Amplio) during 2004 opens a window of opportunity for the development of several structural reforms, whose necessity had been present in the political agenda since the beginning of the second half of the 20th Century. This agenda included a health care system reform, an arena historically characterized by its institutional resistance to change. Because of the complexity of the subsystem, until Frente Amplio came into office, substantial changes had only been made under authoritarian regimes[2].

In this context, the construction of the Sistema Nacional Integrado de Salud (SNIS by its acronym in Spanish) appears as a major change that needs to be studied. With this in mind, the Advocacy Coalition Framework (ACF) seems a very useful tool to understand the process that made reform possible. But besides this contribution to a particular case, the study of Uruguayan Health Care Reform provides new insights into the improvement of the framework in two dimensions: on the one hand, it contributes to

[2] Uruguay suffered during 20th Century two democratic turndowns, the first one between 1933 and 1938, and the second one between 1973 and 1984.

seeing how the framework works in new contexts like Latin American Southern Cone. On the other hand, the case presents some features that could help to advance in some issues that have not been deepenedas Weible & Sabatier (2006) or Sabatier & Weible (2007) point out.

Basically, by studying what the political and institutional conditions that allowed Frente Amplio´s government to pass the reform were, we will discuss the need for having at least two rival coalitions and how the context and institutional legacies affect the coalition opportunity structure.

What this paper will show is that political struggles are made within a major advocacy coalition. In contexts where there is no clear competition between coalitions because historically the political system has developed a consensual logic of negotiation which privileges institutional stability, as happens in Uruguay, the scope of changes will necessarily be narrower. Following that logic of action, the most probable results in this scenario are incremental and gradual changes with great stability.

Despite this general context of stability, in Uruguayan health care subsystem we have identified several competing coalitions which are small and organized around instrumental issues or specific interests, but there is no coalition with the intention to promote structural changes. In other words, the institutional environment does not promote the formation of coalitions based on a systemic project of reform. Within this context, the particular factor that made the reform happen was the change in government. Despite the general crisis, without the arrival of a leftist party with a project of change, the window of opportunity would not have opened.

Another important fact to take into consideration is the inclusion of negotiation opportunities instead of imposition from the government, which resulted in the engagement of several interests that allowed the construction of a broad advocacy coalition for the reform. Following this pattern, actors who historically played a veto role regarding substantive changes were incorporated into the coalition.

This paper is divided into another four sections. Firstly, the main components of the Advocacy Coalition Framework will be presented in order to identify its main strengths and critics and from that we make the questions which guide the rest of the work. Secondly, we characterize the Uruguayan health care subsystem with its more important actors in the context of the existing welfare regime and its transformations since 2005. Thirdly, we rebuild the political process which made reform possible by

applying ACF instruments[3]. Finally, we end the paper by discussing the evidence seeking to provide some keys to the following:

1. Better understand the reforms promoted by leftist parties in Latin America; and,

2. Contribute to deepen the reach and usefulness of the ACF, not only by its application to new cases, but also by adding new evidence to discuss.

2. Theoretical framework: ACF and institutional change

This paper takes a look into the Advocacy Caolition Framework (ACF) proposed by Jenkins-Smith and Sabatier (1993), Sabatier and Jenkings-Smith (1999) and Sabatier and Weible (2007) among other works. ACF can be viewed "…*as a lens to understand and explain belief and policy change when there is goal disagreement and technical disputes involving multiple actors from several levels of government, interests groups, research institutions, and the media*." (Hoppe and Peterse, 1993 in Weible and Sabatier, 2006: 123)

Differing from traditional approaches used to study public policy, which are based on the idea of cycle and look at the policy programme as its unit of analysis, the ACF adopts a bottom-up approach by considering the diversity of actors involved in the policy process, both public and private. Those actors should not be studied in isolation, and that is why this approach takes the concept of coalition. From this perspective, institutional and political change could be understood as the result of the struggle of competing interests defended by different actors, generally organized and coordinated around what can be called an "advocacy coalition". Besides sharing a set of policy beliefs and aiming at realising them "…*by influencing the behavior of multiple governmental institutions over time*" (Sabatier and Jenkins-Smith, 1993:186), these coalitions are also characterized by maintaining certain stability over time (Zafonte and Sabatier, 2004).

However, the beliefs and values of the actors forming a coalition are not identical, among other things because reality is much more complex. Actors tend to join in structures that present similarities to its core beliefs and interests. According to the framework, the closer actors' beliefs are, the higher the stability of the coalition. Usually, once the coalition is formed, it is very difficult that it react actively to external elements; so, coalitions, as well as policies or institutions, are very reluctant to adapt to changes (Sabatier and Weible, 2005).

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[3] For this purpose, the information presented in this paper and the position of the health care actors is based on interviews made for previous works such as Fuentes (2013) and Rodríguez Araújo and Toledo (2010).

In this regard, coalitions do not form randomly. What brings the cohesion is the belief system, which is composed of three levels (Sabatier and Weible, 2007). "*At the broadest level are deep core beliefs, which span most policy subsystems. Deep core beliefs involve very general normative and ontological assumptions about human nature, the relative priority of fundamental values such as liberty and equality, the relative priority of the welfare of different groups, the proper role of government vs. markets in general, and about who should participate in governmental decisionmaking. The traditional left/right scales operate at the deep core level. Deep core beliefs are largely the product of childhood socialization and, thus, very difficult to change*." (Sabatier and Weible, 2007: 194)

At a second level of this system is the policy core beliefs, which includes those ideas about what should be done in a particular policy subsystem. Although this group of beliefs is also resistant to change, they are more plausible to be transformed than the deep core beliefs, mostly in the mid or long term. It includes aspects like perceptions of the subsystem wide problems, orientation on basic values priorities related to the policy subsystem, or the desired distribution of authority between the State and the market (Sabatier and Jenkins-Smith, 1999).

In the third place, secondary beliefs are political preferences related with particular dimensions of the subsystem. They could be actors' preferences about, for example, management tools and other specific aspects of a subcomponent of the political subsystem, or a local perception of a problem. In comparison with the other levels, these beliefs are the easiest to change, taking into consideration some variations in the context or the existence of new information available.

Since changes are difficult to implement, ACF assumes that advocacy coalitions based on policy core beliefs will be more plausible to promote significant transformations in the policy subsystem, while those coalitions constructed around secondary beliefs will have less impact on the orientation of the public policy. Originally, the approach took into consideration the existence of external events as a condition to the existence of major changes only, like socioeconomic variations, changes in public opinion or in the governing coalition, and decisions made in other policy subsystems (Weible and Sabatier, 2006)

This aspect was reformulated later with the addition of the possibility of internal shocks as promoters or enabling major change to the framework (Sabatier and Weible, 2007). This modification is based on the recognition that both internal and external shocks redistribute political resources, shifting the incentives to maintain a coalition and also restructuring the balance of power between competing coalitions. These internal

movements, generally speaking, reinforce policy core beliefs of the minority advocacy coalition, and at the same time erode the foundations of the dominant coalition.

At this point, it is important to consider another addition to original version of the ACF: the importance of the coalition opportunity structure to determine or condition the number and type of coalitions in any policy subsystem. "*Opportunity structures refer to relatively enduring features of a polity that affect the resources and constraints of subsystem actors. In our case, we are interested in factors that strongly affect the resources and behavior of advocacy coalitions*." (Sabatier and Weible, 2007: 200) Virtually in all the cases where the ACF was applied, the scenario reflects the existence of two or more competing coalitions, but no dimension of the model of analysis seems to require this configuration.

In fact, it could be the case that the coalition opportunity structure defines incentives for dealing with subsystem problems within one single coalition, because of the difficulties associated with the collective action required to organize a rival coalition. As it will be show later, this seems to be the case of the health care subsystem in Uruguay. In general, competing coalitions tend to organize around explicit projects of change: one promoting the reform, and the other opposing to it. The problem with this model is that assumes that there is an explicit project reform of transforming reality. The problem with this idea is that many times, there are no actors who develop a systemic view in order to lead the coalition construction process.

In contexts with weak State structures and powerful private actors, the transformation of the subsystem seems difficult to achieve because the action of the second ones lacks interest in systemic values and improvements. This scenario is referring to the Uruguayan case but could also be present in other Latin American countries. Within these cases, institutional change only seems possible with a variation (whether external, internal or both external and internal) in the distribution of power between actors which leads to a reinforcement of the State authority. Even with this configuration, the reach of the reform is strongly dependent on the type of the political bargaining.

What we will show in the next section is that the inherent complexity of the health care subsystem, in addition to the historical legacy of the country (strong centralism and a political culture which prioritizes agreement and consensus instead of conflict) poses difficulties to the existence of multiple coalitions. Moreover, in the case of the creation of the SNIS, the advocacy coalition was integrated by all the sectorial actors for which the status quo was no longer a valid option, but more importantly, by the State, who brings an alternative political project. Because the conflict was not hidden and there is a wide heterogeneity of interests and beliefs, the competition was moved to the implementation stage, where secondary aspects become more significant.

While the ACF develops a model of analysis which can be used in different subsystems, we need to recognize that there are characteristics that could impact over the conditions to create an Advocacy Coalition in a significant way, but most importantly, to promote significant changes. In this way, several authors have focused their attention in studying the political and institutional conditions that make welfare reforms possible, some of them also identified by ACF works.

One example is the review of factors made by Del Pino and Colino (2006) identified in order to determine the failure or success of a reform proposal these main conditions: (i) the trajectory (path dependency) of public policy (the organization of interest groups, modes of funding, etc.); (ii) electoral constraints, which make parties consider the political and electoral costs and gains of any decision; (iii) the existence of veto points and also the level of power fragmentation; (iv) the type of participation of social actors in the conduction of the subsystem (when there is some kind of involvement of social actors in the governance structure, the government requires to negotiate more with its partners); (v) the ideological orientation of government; and (vi) the reform style (more or less flexible to adjustments).

In political arenas where the actors have relative veto power, the need of some kind of consensus appears as a fundamental prerequisite. This is the case of the health care subsystem, because the configuration and diversity of actors and multiple interests fragment the political game. That is why some authors talk about a "nested system" where "*…the actor moves simultaneously in several boards and therefore, its behavior is not only the result of the resources and ideology, but also to the cross incentives, and even contradictories, which impose the games in which they play*."[4] (Acuña and Repetto, 2007: 30)

Another dimension to take into consideration from a theoretical perspective is the differential roles that many times adopt certain specific actors: the distribution of power inside a coalition is rarely homogeneous between its members, and in some cases political elites arise as key players (Grindle and Thomas, 1991). Political ideology, expertise, technical capacity and leadership, are all important resources used by these elites to condition the decision making process. According to these authors, the virtuous combination of these features with the appropriate way of handling the political agenda allow them to extend the political space to move the policy more closely towards the desired direction.

[4] The translation is made by the authors.

Taking those factors into consideration, reformers must value "…*the distribution of costs and benefits of a policy or institutional change, its technical complexity, its administrative intensity, the point in which incorporate the active participation of bureaucrats or beneficiaries, and its short and long term impact*." (Grindle and Thomas, 1991: 4)

At this point, it is necessary to incorporate a dynamic perspective into the analysis of public policy (Kay, 2006), because the issues mentioned until now help to explain under what conditions the status quo could be broken, but this is explanations tell us almost nothing about the rest of the political process of implementation. The implementation game restarts the conflict inside any subsystem, and in many cases it could also redistribute some power between agents, inside or between coalitions as a result.

Considering the case treated here, when the continuity of the status quo was no longer an option, some actors with veto power preferred to be part of the advocacy coalition instead opposing to the reform. By taking this strategy, actors like private providers were able to influence the orientation of the most critical changes (especially the financial ones) during the formulation and negotiation of the reform package. Then, they consciously limit the implementation of those changes that would imply more costs in terms of economic power, transparency or important management improvements in the regulatory structure of the new system.

3. Welfare Reforms in Latin America: the health care sector in Uruguay

Last decades of 20th Century and the first years of the 21st have witnessed multiple changes around the world in terms of social, political, and economic development. Such transformations have influenced and force the accomplishment of several reforms in areas like welfare provision (Palier, 2010; Pierson, 2000; Esping Andersen, 1993; among others).

In relation to this arena corporatist or conservative structures are, generally speaking, those who are more resistant to be changed. This resistance to changes responds to its institutional structure and the existence of multiple actors and interests involved. The direct consequence of this configuration is that once certain decisions are made, it tends to set up a strong net of interests which works as a powerful veto actor, integrated by multiple actors with an important amount of power resources. That is why the literature usually identifies these welfare regimes as "frozen landscapes": they are contexts where it is extremely complex and difficult to promote structural transformations (Hausermann, 2010; Palier and Martin, 2008).

The reference to corporatist welfare regimes and its characteristics is important because historically Southern Cone countries in Latin America (Argentina, Chile and Uruguay) have built social protection schemes, productive structures, and systems of labour relations very similar to those that can be found in a particular subtype of corporatist countries, the Mediterranean ones, like Italy, Portugal, or Spain (Bogliaccini and Filgueira, 2011).

One of the salient features of Latin America´s Welfare Regimes is it heterogeneity, but despite this fact, all cases present a common feature which is the informality, as in labour relations as in other subsystems (Wood and Gough, 2004). Specifically, the Uruguayan case has been considered by authors like Fernando Filgueira (2007) as an example of “Stratified Universalism”, together with the other Southern Cone countries. These countries managed to achieve, by the half of the 20th Century, an almost universal coverage of the main social services: health care, social security, and education. This configuration was not the result of an explicit Universalist project, but rather it was a *de facto* outcome of the combination of extremely stratified structures with high levels of formal employment.

By the beginning of the new century, the financial and economic crisis that strongly impacts in the region laid the foundation for leftist and progressive parties winning the access to government. A quick look at these governments seems to exhibit that they have been successful in reversing the re-commodification trend developed by previous governments. This fact does not imply that they have managed to install and consolidate structural reforms towards a social democratic style of managing public policies.

Therefore, if we adopt the premise that Uruguay, together with its regional pairs, are examples of a corporatist welfare regime, it seems logic to conclude that inside this regime, the different subsystems will be particularly conflictive to promote any kind of major change or reform. As an additional complexity it can be mentioned the context of informality in productive and social terms. Within this context, the healthcare sector appears as a clear example of institutional resistance to change.

The system was built and bounded during the first half of the 20st Century in a very atypical way within the region, because of the wide territorial reach of both public and private providers, the high levels of coverage, and the early demographic and epidemiologic transition which its population have lived (Pereira et al, 2005). However, the performance of the system was getting worse progressively, in part as a result of the worsening of economic indicators, but also due to the State weakness in terms of regulation. This systemic bad condition derived during the next decades in a permanent state of crisis (Dibarboure, 2003).

Among these problems one could highlight the already mentioned weakness of the State to really fulfill its basic responsibilities in terms of public health; the absence of coordination and complementarity between public and private subsystems, the fragmentation, and management problems associated to the provision of services; a model of provision based on strong specialization and curative attention; and finally, the absence of comprehensive approaches that provide answers to the population new structure of risks. The different attempts to solve those issues under democratic regimes have not been successful (Moreira and Setaro, 2000; MSP, 2009 and 2010).

The 2002 general economic crisis, with its subsequent increase in the levels of unemployment, poverty, and extreme poverty rates; exogenously got worse the existing situation in the health care subsystem, making the demand of public services rise. Financial problems within providers aggravated even more, and ended in the closure of some private providers because of insolvency. The direct result of this context was the growth of the inequities between the public and private sector, and a systematic fall in the quality of attention, which ended in major dissatisfaction of an important number of social groups.

The package of reforms announced for this first time in office included a diverse set of reforms, all of them with high levels of complexity, linked to some of the components of the welfare matrix, or at least with strong influence over them[5]. Generally speaking, the main changes posed, showed as a general objective the revalorization of the public action as an enabling factor to reach more and better equity conditions among different social sectors.

From this setting of parliamentary majorities, it could be expected that the definition and adjustment of these reforms take place in a negotiation process within government, and also with the rest of the party structure. The picture is completed with the specific social actors of every subsystem. The way the FA handled all these variables would be determinant for the timing of implementation of every reform, influencing their progress, stagnation and reversals. Therefore, the idea of creating a Sistema Nacional Integrado de Salud (SNIS) came in a political tempo was the agenda was full of issues. In a way, this complex agenda could be helpful to dilute some kind of opposition by the

[5] The set of changes that took place during first Frente Amplio´s administration was vast. A non-exhaustive list of them includes the health care reform, the labor reform with the reinstatement of collective bargaining of wages and work conditions between workers, employers and the State (Consejos de Salarios), the reformulation and the extension of non-contributive monetary transfers, the creation of a ministry of social development with the immediate responsibility of coordinate the all ministries related to social issues in order to mitigate the effects of 2002 crisis, and the call of a wide social dialogue about education which ended in the approval of a new education bill.

relegation of the political discussion to a second place, since the health care reform was perceived with less relevance in terms of redistributive struggles.

4. The construction of the SNIS: the building process of an advocacy coalition

In Section 3, the inherent complexity and diversity of actors involved in any healthcare system, with the addition of having strong power resources which are mobilized in order to fulfill actors´ interests was mentioned. The Uruguayan healthcare system does not escape from this situation and it could be considered as a clear example of a "nested system". That is why it is extremely difficult to address the positions and interests of complex collective actors, because depending on the juncture or the issue in question, the reactions of these actors can vary. The position assumed by the actors will be analyzed in this section.

Broadly speaking, the reform project proposed by the new government aimed at modifying the ways of funding, managing, and providing services. This objective implies the strengthening of the capacities of the State as a regulator (but also as a provider) seeking to articulate the action of public and private providers. A distinguishing mark of the process was that, while the new pillars of the system were agreed, there was a process of formalization of the direct involvement of most of the main sectorial actors.

The electoral victory of 2004 implied for the Frente Amplio the control of the Executive but also the absolute majority of seats in the Parliament. However, the composition of both chambers did not give room for any kind of indiscipline inside the party. This situation forced that the political definitions and adjustments of the reform for each issue take place mainly during negotiations inside Frente Amplio´s structures. At least in this subsystem, the relevance of opposition parties was diminished to information requests or public statements without major effects. Moreover, the fluctuations in the positions adopted by some social actors could be associated with moments of bigger or lesser incidence of fractions loyal to opposition parties. In this process, all key actors inside the Executive were part of Frente Amplio and followed the same political manifesto. However, the important number of State agencies involved in the reform illustrates the multiple interests that played during the formulation and implementation process.

In the case of civil society actors which participated in the negotiation of the SNIS, the situation was even more complex, since the same actors simultaneously perform several roles (political, business, unions, academic, professionals, etc.) and therefore the meaning of their actions is difficult to identify. The paradigm of this situation inside the healthcare system are physicians because, with its multiple associations, they are linked

to or even developing a major role inside political parties, business associations, providers of high tech, laboratories, human resources centers, private clinics, and pharmaceutical companies.

This fact implies that assigning a general position to this actor (i.e.: physicians) without taking into consideration some definitions about their particular role in the field of analysis is very difficult. For example, while the Sindicato Médico del Uruguay (i.e: the major medical organization in Uruguay) was in favor of the SNIS most of the time, it changed its position due to a new leadership closely linked to right-wing parties (Partido Nacional and Partido Colorado) during the initial steps of the implementation of the new system. Those changes were a consequence of the internal political life inside the organization, which makes it very difficult to assign a regular behavior inside it. Moreover, there is also another medical organization called Sociedad Anestésico Quirúrgica which is integrated by unions of different specialists like surgeons and gynecologists. This association had developed a consistent resistance to changes, even by promoting several mobilizations and conflicts with health authorities. Almost all of these mobilizations were motivated by economic issues.

On the other end, there are the non-medical workers, who could be associated with the main promoters of the reform, although it is possible to identify also some nuances. Even though workers of private subsystem grouped in the Federación Uruguaya de la Salud are in the vanguard of the process, those working in the public sector (belonging to the Federación de Funcionarios de Salud Pública) just give the reform a transitory support, because its ultimate goal is the installation of a healthcare system integrated only by State facilities, similar to the Cuban healthcare system.

In the side of the users of the system, although they potentially composed the most numerous group (every citizen in the country) given its emerging organization and dispersion of interests, this group has been not consolidated as a determinant collective actor for the process yet. Despite the lack of consolidation, they have manifested in favor of the changes proposed.

In terms of provision, health providers are separated into three different types. First, there are “social” providers or “mutualistas”. These are approximately 40 non-profit organizations in the country. Historically, they had been the major healthcare provider, covering around one half of the population since the mid 50´s. Second, there are seven health insurers which are for-profit private organizations covering nearly 5% of the population with the highest levels of income in 2013. Finally, the system also has public providers (Administración de Servicios de Salud del Estado - ASSE, Sanidad Militar, Sanidad Policial and the Hospital de Clínicas, which is a university center). Except for the public providers, other providers are integrated to some business chamber, and through

these associations have influenced the multiple spaces of negotiation that the government had called for.

To sum up, the actors mentioned before are the main actors in the Uruguayan healthcare system. The revision of the process which resulted in the creation of the SNIS departing from the idea of an advocacy coalition who gave political viability to this change could be analyzed taking into consideration the different stages of the public policy cycle. Disaggregating this process from this point of view allows obtaining a dynamic and less linear perspective of the process, and also makes it possible for us to trace some changes and adjustments in the behavior of actors, which necessarily affects the composition and strength of the coalition.

In this regard, it is also relevant to highlight that, for each stage of the formulation process of the SNIS, the three levels of the belief system considered by the ACF will play different roles. This process is analytically disaggregated into three stages as follows: (1) the previous years to Frente Amplio´s victory in 2004, which contains the consideration of the issue into the political agenda; (2) from 2005 to 2007, when the design and formulation of the SNIS took place; and (3) from 2008 when the implementation starts.

4.1. *Main stages of the SNIS´s building process (2000-2014)*

Prior to the electoral victory of Frente Amplio, but even before the crisis that affected Uruguay in 2002, there were different proposals around the reform of the healthcare system within the sectorial actors. These expressions constituted an important insight for the Frente Amplio to make a proposal, but most importantly, these alternatives were the expression of one aspect that constituted the core belief of the advocacy coalition: the conviction – either ideological or by instinct of surveillance – that something had to be done in the subsystem. Hence, the defense of the status quo was not a viable option a priori.

Therefore, the consensus around the need for a reform was not the only factor shared by the actors inside the coalition. With the exception of non-medical workers of the public sector, the rest of the system defended a provision structure moving around non-profit private providers (the "mutualistas"). That is why, when the arrival of the Frente Amplio opened a window of opportunity to promote several transformations in healthcare issues, the subsystem as a whole seemed to be prepared for this with what should be recognized as an advocacy coalition.

However, the following years were not exempt of conflicts and ups and downs about how to reform the system. Nevertheless, the role assumed by the government and its strategy were characterized by the search of negotiation and a lot of flexibility allowed

that any actor would remain outside the negotiations. With this orientation, the new health authorities called a Consejo Consultivo para la Implementación del SNIS, to which all sectorial actors were invited, as their very first measure.

During the second stage of the formulation, the deep core beliefs started to lose centrality. At the same time, the political aspects began to dominate the dialogue. Thus, once the reform was defined as a common goal, the question was what its orientation would be. Based on the reconstruction of the legislative process which resulted in the approval of the main laws of the new system, it is possible to identify those policy core beliefs that were subject to adjustment by several actors. In this regard, the first law passed established the administrative decentralization of the main public provider (ASSE) from the Ministry of Public Health.

It is not strange that this norm has been the first one or that its approval counted with the support of all the political parties in the Legislative, because ASSE´s decentralization had been proposed by previous governments since the re-democratization in 1984. Administrative decentralization was, according to health authorities, an essential precondition for the public provider to effectively modernize its structure, but even more importantly, its mechanisms of management. This first decision did not generate any vetoes since the public sector in Uruguay had developed a residual role in terms of provision, focusing almost exclusively in the attention of the most needed collectives.

From another point of view, a novelty of this project was the incorporation of representatives of users and workers in ASSE´s board and the creation of a consultive council with the same integration. In this case, the major concern was focusing on the public sector actors, and that is why the private ones did not play a significant role. Clearly, the unified union (PIT-CNT) and user organizations supported these innovations while physicians were contrary to their exclusion from the board.

This aspect is still important for the physicians, who until now are trying to change this configuration. In fact, in many instances of negotiation, for example the spaces which discuss the transit to a primary care model, they introduce the issue as a bargaining coin although this process remains stuck. However, the participation in the governmental structure of the subsystem is not essential to the union because they are a collective actor with a number of power resources that they can mobilize to incide in the decision-making process despite SMU's formal presence in some spheres.

The second step for the creation of the SNIS was the extension of the existing coverage, using the traditional mechanisms of social security system. That led the process to a second general law, which consisted in the creation of a Fondo Nacional de Salud (FONASA). This fund is composed of contributions of workers, firms, and the State. The first ones make a proportional contribution which, above a minimum threshold, varies

according to the existence of children in the family or other dependency situation. This change was agreed on inside the coalition since the extension of the coverage of social security contributors implied more economic resources for the providers, mostly private ones, which were in a precarious financial situation.

Non-medical workers also agreed with this movement because salaried workers and their families could incorporate into the FONASA. This innovation resulted in an improvement in terms of the diversity of services guaranteed by this kind of coverage. This second step also proposed to enable the competition for new affiliates between ASSE and private providers, unlike the pre-existing system in which the public sub-sector was not an option for formal workers.

The third normative pillar of the reform was a law (18.211) which explicitly created the SNIS. This project was presented in the Senate in March of 2007. In relation to the substantive issues, the proposal reasserted some of the main principles and objectives previously mentioned such as the equity of the funding scheme, the quality of attention, the social and economic efficiency, and social participation, among others. This goal would be achieved by the implementation of changes in three dimensions: attention, management, and funding.

Taking into consideration the main transformations related to the management model, an undoubted milestone was the creation of a Junta Nacional de Salud (JUNASA) as a deconcentrated entity from the MSP, which is responsible for administering the National Health Insurance and promoting the coordination and complementarity between the services and levels of attention. The JUNASA also has the task of redirecting the model of attention to a primary care system through the definition of health care goals and the signature of performance contracts between the State and each provider. Finally, the JUNASA should bring transparency to the process through the incorporation of the main sectoral actors, both from government and the civil society.

From this brief look at the normative pillars of the SNIS, it can be seen how, in some cases, the negotiations did not include all the coalition, mostly due to the specificity of the issues. Moreover, the existence of some refinements essentially linked to certain political orientations about the role of the State as a rector of the system emerged as well, which was, in principle, a clear contradiction of the commercial goals of private providers, who advocated for more liberty of action.

In this regard, the advocacy coalition started losing sustainability when the implementation phase began, by the beginning of 2008. Since then, secondary beliefs have shown great disparities between actors. This situation of greater conflict was reinforced by the very dynamics of implementation that create resistances from some actors, especially from the attempts to promote increasing regulation. That was the case

of the new mechanism of payment to the providers by each affiliate, which consisted in a per capita basis adjusted by age and gender, as in the majority of cases around the world. With the access to some comprehensive package of services for almost all the population, the extension of the insurance expands the choice of users, decoupling it from the level of income or the prior health condition.

For this reason, private providers tried to influence the implementation of regulatory innovations, in the same way that it was done during its design (by reducing the minimum standard). In relation with this point, it is interesting to notice how the actors, who could have felt negatively affected by some changes, instead of choosing a direct opposition which block the proposal, oriented their actions to influence or affect the implementation process. In a consistent way with the postulates of the ACF, secondary aspects were part of the explanation of why the coalition was not sustainable in the mid-term.

It is also necessary to consider another aspect which contributed to a deterioration of the advocacy coalition strength: the dynamics of implementation chosen by the own government. Given the context of crisis and the pressure made by some actors, the first changes aimed at finding the solution to the financial problems of the system.

With these transformations, several private providers could overcome their structural crisis because of the stabilization and even the ampliation of the main source of income. Since the creation of the FONASA, the tendency is for the number of affiliates in the private subsector to rise to the detriment of its public counterpart. The growth of the private subsector allows inferring that private providers have become critical allies of the reform process.

Thus, the implementation process undermined the basis of the deep core beliefs of the coalition because once the survival goal was accomplished, private providers saw the threat of increasing State intervention and regulation in all the remaining changes. That is why their position towards the reform changed. The final section presents some reflections linked to the conditions which favoured the approval of the reform and its impact in light of the sustainability of the advocacy coalition and thereby, the reform itself.

5. Final comments

Frente Amplio´s first government was characterized by the promotion of several sectoral reforms, such as the ones in the economic, productive, and social arenas. These reforms were promoted in a conjuncture of the end of a strong social and economic crisis. In this regard, the context appears as one of the main conditions which enabled

the agreement between actors who were, during the 20th Century, directly confronted in terms of public policy advocacy. Therefore, the consideration of the difficulties associated with the consolidation of the coalition, in the long term and during the changes in the conjuncture, could be explained by the starting power of the coalition.

Formerly, the sectorial crisis was recognized by every actor within the subsystem. In addition, during the last decades other governments presented reform projects based on these diagnoses, and also enjoyed parliamentary majorities. However, none of them could achieve concrete results. From this perspective, what were the factors that have been present that led to the promotion of some kind of change in this case? Fundamentally, those factors were present in the way that the Frente Amplio managed the process.

Thus, the existence of a complex agenda with multiple fronts, allowed the generation of some space in which the health authorities could move and negotiate within an environment of lower public exposition.

Another point has to do with the fact that ambitious health care reforms require wide consensus about its main principles. This was not possible in the Uruguayan healthcare sector in previous attempts to reform. What changed, and was a determinant factor in the new scenario, was the “flexible style” adopted by the health authorities to guide the discussion of the reform (Rodríguez Araújo, 2011).

This strategy is linked to a third aspect of the political economy of the SNIS that is worth some emphasis: the political decision of delaying all the issues that would potentially activate the different veto players. In this way, the configuration of the implementation process resulted in a sequence which prioritized the funding aspects (the main concern of most of the actors) and move on (although with uneven rhythms) in relation with management matters, but virtually left those structural issues such as the model of attention and care, untouched (Fuentes, 2013).

Actors with veto power – such as mutualistas – focused their actions on promoting those elements associated with the ways of funding the system and on blocking the tools with which the State would enhance its capacities to guide and control the system. In terms of social participation spaces, the negative reactions only arose when some actors felt excluded from some decision points or when those actors considered that the powers of workers and users were “excessive”.

Therefore, it could be inferred that the multiple reforms promoted jointly increased the succeeding options of healthcare reform, but inside the subsystem, the way of dealing with socio-statist interfaces behind economic and regulatory issues could have favoured

a less ambitious level of development than the one initially expected by the promoters of the reform.

In short, the case of the Uruguayan healthcare subsystem seems to give an account of an advocacy coalition which, broadly speaking, showed few agreements in its deep core belief system, but which was able to group different actors in relation to some ideas from the political belief system. In this regard, they shared the belief of the necessity of the reform, but there also was some consensus about the central role that the "mutualismo" should keep playing in the way the system is organized. This agreement around the need of make a reform inhibited the existence of a defensive coalition which wants to maintain the status quo. The result was the creation of a single advocacy coalition.

However, the pacts ended once the main objective was accomplished: the beginning of the reform and the solution of the economic problems of each actor. As a counterpart of this configuration, the existing differences between secondary aspects associated with the tools needed to implement the changes and the transformations required to effectively move towards structural aspects could have imposed an important brake to the reformist impulse.

Another point to consider, when looking the whole cycle, is the role played by the Frente Amplio in promoting the reform, which had decreasing returns. Such factor may be adjudicated to the very dynamics of the process, and also in a determinant way, to the ups and downs inherent to the political cycle, such as the renovation of names in key positions like the President or the Ministry of Health.

Therefore, once the survival of the system was achieved, a new equilibrium point was quickly reached, where the deep core beliefs of each actor came to predominate, rebuilding a "frozen landscape" that made the deepening of the project designed initially difficult. If this hypothesis is true, it could be argued that one of reasons of this situation is the sequence chosen for the implementation of the SNIS, which at the same time gave political viability to the project in exchange of new vetoes and the re-strengthening of actors who were in a weaker condition at the beginning of the process, like private providers.

Finally, based on the Uruguayan case, it might be interesting for us to consider a complementary aspect to the ACF: in complex public policy subsystems, the analysis of advocacy coalitions could be reinforced by the consideration of the cycle of public policy since many times the coalitions who promote a political initiative, or even design them, have not necessarily managed to remain together for the rest of the process.

6. Bibliografía

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