

Gaining public control on health policy: the politics of scaling up to universal health coverage in Uruguay

Xavier Ballart¹ · Guillermo Fuentes²

© Springer Nature Limited 2018

Abstract This study presents the health reform in Uruguay as an example of a country successfully gaining control over health policy and scaling up toward universal health coverage through a national insurance model. The study looks at the circumstances leading to the opening of the policy window and to the politics that made the passage of the reform possible. Evidence is mainly qualitative. The main findings relate to the role the state can play as an intelligent regulator and coordinator; the trade-off facing the governments since consolidating the private and third sector providers can strengthen the opposition to future policy changes; how medical and economic interests do not oppose reforms that preserve their autonomy, and how trade unions will not oppose reforms that simultaneously improve investment and working conditions in the public provider.

Keywords Health reform · Latin America · Policy change · Historical legacy · Professional interests · Professional autonomy · Working conditions public sector

✉ Xavier Ballart
Xavier.Ballart@uab.cat

Guillermo Fuentes
guillermo.fuentes@cienciassociales.edu.uy

¹ Department of Political Science and Public Law, Universitat Autònoma de Barcelona, Edifici B Campus, 08193 Bellaterra – Cerdanyola, Spain

² Instituto de Análisis Político, Universidad de la República, Montevideo, Uruguay



Introduction

Why did Uruguay, with the health reform of 2005, opt to continue with a health insurance model instead of a national health services model? Did health policy change and how does politics account for observed changes? Universal health coverage (UHC) is a concept based on the premise that all the citizens should have access to health care. Considered “the single most powerful concept in health reform” by the Director General of the World Health Organization (WHO) in 2012 (Holmes 2012), there is much diversity in the ways that UHC is interpreted and implemented. Even in the most successful countries of Latin America, like Uruguay and Costa Rica, public health services are universal in coverage but they differ markedly in terms of quality.

The claim that Latin American countries opted for an insurance model during the twentieth century and that the historical legacies and path dependency condition their present choices has been substantiated by a large body of research (Martínez Franzoni and Sánchez Ancochea 2016; Fuentes 2013, 2015). In the case of Latin America, the comparative social policy literature has also pointed to the uniqueness of Latin American economies, the deep social inequality, and dualism as the reason for fragmented welfare systems (World Bank 2004). While more focused social and health policies are supposed to compensate for the adverse effects of labor market liberalization, the failure to increase tax revenues and the preferences of median voters would also explain the option for the insurance model as opposed to a national health service model (Martínez et al. 2009; Iversen and Soskice 2006).

This article addresses two shortcomings in the literature. First, despite income inequality and truncated welfare systems, countries experience change and, as expressed by various scholars (Sheahan 2002), there is a need to account for change and provide a more nuanced explanation of country specificities where we can observe the role of the state and public institutions. Second, there is an insufficient understanding of government—society relations in the context of policy reform. As suggested by Pontusson (2005), considering political struggles and power relations is key to better understand policy change.

Uruguay has been put as the example of “stratified universalism” with extended social and health policies but with significant segmentation (Filgueira 1998). It is also an example of a state orientation rather than a market orientation in the way of addressing the interaction between labor markets, public policies, and families (Martínez Franzoni and Filgueira 2002; Martínez Franzoni 2008). From this perspective, it is a good example for countries willing to improve their redistributive record and engage in more ambitious social and health policies.

This is an observational study that centers on the politics of health reform. We depart from the comparative social policy literature but we use a general policy process framework (Fox and Reich 2015) as this is judged more adequate to study the inclusion of health reform in the government agenda, the different policy options that were considered and the decisions finally taken. Given the breath of the policy process, we limit the scope by considering the organization of health provision, as this is a key issue affecting policy options, but not policy implementation. For the



political analysis, we use some of the “I’s” of political analysis, from ideas and ideologies to institutions and interests. Evidence is presented in the form of official data on the evolution of certain indicators and citations that reproduce the perceptions of the main actors, which were collected through interviews with the main stakeholders. For the reconstruction of the process, political party manifestos and official documents, such as legislative manuscripts, were also used.

The article confirms some of the ideas already present in the literature with regard to abrupt versus incremental policy change, the impact of external factors in the setting of government agendas, and the limitations imposed by the preexisting policy architecture. However, it also provides new insights and a more nuanced vision of health policy reform processes particularly with regard to three issues: (1) the role the state can play as an intelligent regulator and coordinator even if a big part of health provision is essentially private or third sector; (2) the trade-off facing the governments since consolidating the private and third sector providers can strengthen the opposition to future policy changes; (3) how medical and economic interests do not oppose reforms that preserve their autonomy. Governments can opt for a mixed model of health provision and improve the working conditions of the medical profession. What the Uruguayan case does not show, despite the progress made, is the moment where the differences between public and other providers are blurred and the public sector becomes a true competitor in the eyes of citizens and the medical profession.

Theoretical framework

Latin American economic and social policy

A large body of research has established persistent poverty and income inequality as one of the main problems of Latin America (World Bank 2004; Martínez et al. 2009). The region shows significant variations but even the smaller and most successful countries like Uruguay have a large informal sector with a big share of the population depending on irregular wages and with limited access to low-quality public services. Only workers in the formal economy receive social insurance (including pensions and health insurance) and employment protection. Public health services and education are universal in theory but coverage and quality may vary significantly between urban and rural areas.

Various scholars have classified Latin American countries according to their welfare regimes. Huber and Stephens (2001) classified countries in descending order of coverage and fiscal effort. Molina and Rhodes (2007) consider that Latin American countries can be compared with Southern European countries experiencing high levels of economic inequality. Other scholars consider that reforms like the privatization of pensions and the liberalization of the labor market have weakened the protection of formal sector workers (Barrientos 2004, 2009). For Martínez Franzoni (2008), informal arrangements interact with public policy resulting in a more universal but stratified social protection.



An established explanation for the difficulty to expand social and health policies in Latin America is that middle classes fear the redistribution towards the poor. As explained by Iversen and Soskice (2006), presidential elections are determined by the median voter and, although legislative elections follow proportional electoral rules that could help to promote redistribution, economic inequality generates social fragmentation, weakens the power of trade unions, and reduces the political influence of the poor.

However, in the last 20 years, a majority of countries have engaged in a debate over economic performance, social and health protection, and many governments have introduced significant reforms in various policy areas. Arguments advocating universalism are not only emanating from health international organizations but also from institutions in other policy sectors (Banco Interamericano de Desarrollo 2006).

Health and policy formation

The aim of this article is to account for change and to provide a more nuanced explanation of political struggles and power relations in relation to reform in one sector. This is why we use a general policy process framework (Fox and Reich 2015) which helps to explain the inclusion of health reform in the government agenda, the different policy options that were considered and the decisions finally taken.

The Fox and Reich (2015) framework can be synthesized as a four by four matrix of the four classical stages of the policy process, and the four “I’s” of political analysis. However, since a mechanical application of this matrix could result in giving equal weight to political elements that may not be equally relevant at each stage, emphasis is given to “ideas,” “interests,” “institutions,” or “ideology” depending on the issues that are characteristic of each policy stage and the role they played in the case in accordance with the frequency they appeared in the interviews with the main actors.

The use of the policy cycle originally proposed by Jones (1970) has been criticized for presenting the policy process as excessively rational, linear, and ordered, while policy making is normally much more complex (Brewer and de Leon 1983). However, we find it useful to put order in the analysis of a political process that is necessarily complex, take the perspective of the entire process instead of focusing on one stage, and analyze different political processes at each stage.

According to the public policy literature, the first step for an issue is to become part of the national policy agenda. The main questions at this stage are the opening of the issue in the problem stream of a government (Kingdon 1995) and the initial construction of the problem (Stone 1989). Party *ideology* and policy entrepreneurs are important to explain the introduction of the issue in the politics of the country (Kingdon 1995; Roberts et al. 2004), while policy *ideas* and their national or international origins are relevant for the way the problem was initially constructed (Baumgartner and Jones 1993; Kingdon 1995; Sabatier and Jenkins-Smith 1999; Sabatier and Weible 2007).

The second stage in the policy process is policy design, which refers to the definition of the content of the policy and the choice to favor a particular policy



solution with specific characteristics (Fox and Reich 2015). At this stage, *ideas* are important. Policy ideas can be the result of adapting policy proposals that have been developed and implemented in other countries (Weyland 2005), or they can be the result of a domestic debate on the current national model when it has not deemed satisfactory. As reported by Nelson (2004), this is particularly relevant in Latin America. A related issue is whether policies are introduced by special *interest* groups trying to convince the government of the advantages of their policy solutions by responding to a popular demand, or they are the initiative of a group of technocrats working in the administration, or in close relation to the ruling political party (Immergut 1992). Given the financial implications of some policy solutions, finance ministers can play an important role as gatekeepers in the policy process (Kingdon 1995). This is accomplished by either giving support to policy solutions that are financially sustainable or blocking the way to reforms that may disrupt the public finance of the whole country (Lakin 2010; Fox and Reich 2015).

The third stage in the policy cycle is the formal adoption of the policy, normally through the passage of legislation in the legislative chambers. Political *institutions* are more relevant at this stage, since they can become veto points (Tsebelis 2002). There are significant elements in the political analysis of the policy process: the number of institutional veto players, such as the president or the legislative chambers; the number of political parties that have veto power depending on the electoral results; and the points in the legislative process in which policy reform can be blocked, given the particular institutional and political configuration during a specific period. *Ideology* and special *interests* are important to secure the votes to convert policy proposals into legislation (Fox and Reich 2015). Party discipline and political competition may determine how political representatives vote. Special interest preferences need to be taken into account, as their group preferences can be translated into legislative votes through political institutions and pro-government or opposition political parties. Furthermore, professional associations and unions can raise the level of conflict and influence public opinion.

The final stage that is considered is implementation. Often, governments pass legislation and approve a new policy that is never implemented, or they never approve the funding that is necessary to make the new policy a reality (Levitsky and Murillo 2009). Implementation issues are essentially related to *institutions* and their abilities to create the financial, administrative, and regulatory capacity that the full development of the policy requires (Fukuyama 2004). Another important aspect of institutional analysis is the path-dependent dynamics that make changes difficult, given the inertias of the past (Wilsford 1994; Pierson 2004). Implementation is also related to *interests*. They can be electoral interests when reelection of the incumbent party is dependent on demonstrating progress in the implementation of certain policies (Fox and Reich 2015). They can be corporative interests of professionals affected by changes in the organization of health services, or the interests of beneficiaries who value attaining access to better quality services, reducing their exposure to rationing or to unreliable medical practices.



Methodology

This article focusses on the case study of the health reform starting in 2005 in Uruguay. This case study was chosen because Uruguay can be viewed as a model for other middle-income countries demonstrating certain circumstances—democratic consolidation, economic growth, and government stability—that make them good candidates to facilitate significant progress in their expansion of UHC. It is a case of incremental change, showing progress in terms of the state regaining control over health provision by strengthening the idea of an integrated national health system. As such, the country was able to increase solidarity and financial risk protection, while securing the health provision by a combination of private, third sector institutions, and a public provider. Additionally, Uruguay is a country where the health policy community is rather small, and it is possible to reach politicians, high officials, health professionals, insurance business owners, and union representatives.

Few studies analyze the politics of health reform. The case is relevant in relation to the general problem regarding the expansion of UHC in countries that (1) have exhibited difficulties with the quality of the provision of public services, and (2) opted to improve the coverage of citizens through private or third sector mutual organizations while, simultaneously, increasing the investment of general tax resources in the improvement of direct public services.

In order to build the case, we used three sources of information. First, official documents from the government of Uruguay, in particular, the approved legislation, political party manifestos, and various documents produced by the administration to explain the reform. Second, open data on the evolution of key indicators that give partial information on various key outcomes of the reform. Third, the subjective perceptions of the promoters of the reform and other key stakeholders. We conducted 20 in-depth semi-structured interviews with politicians from the presiding government and opposition parties, high officials from the ministry of public health and the ministry of finance, business representatives from the health insurance sector, doctors and nurses working in the public and private sectors, and union representatives from the public sector. Interviews were carried out face-to-face during two periods, 2012–2013 and 2014–2016, with the purpose of giving the reform sufficient time to produce its effects and discuss the same issues with some of the interviewees. The annex provides detailed information about the interviews. In the analysis, we reproduce quotes that can be interpreted as indirectly supporting some of the theoretical propositions regarding the political processes at each stage of the policy cycle.

Uruguay national context and the health reform

Since the beginning of the twentieth century, the state in Uruguay has played a residual role in both the provision of health services and as a regulator of the health system (Antía 2017). As expressed in one of the interviews by a politician



from the government, “the system was self-regulated.” Access to health care was historically associated to participation in the formal economy, and the provision of health services was in charge of a mixture of private-for-profit and non-profit organizations known in Spanish as “mutualistas.” This system was started by the so-called “honorary councils” that were created in each trade or industrial sector. These councils reached agreements with the non-public health organizations, later known as IAMC, because they refused the provision of health services through public agencies, today known as ASSE. For many years, the health sector in Uruguay was characterized by the presence of private and third sector organizations and the weakness of the state. Successive governments had difficulties promoting reforms. In 1941, 1952, 1967, and 1972, different health reform projects were proposed, but none of them were approved (Fuentes 2013). This was the foundational policy architecture of the Uruguayan health care system, the blueprint of policy instruments set up by state in an initial effort to organize social benefits (Martínez Franzoni and Sánchez Ancochea 2016).

Compared with other Latin American countries, Uruguay enjoyed high levels of employment at various times in the last century, which translated into the highest levels of health coverage for the continent. However, in 2002, Uruguay plunged into a deep economic crisis with high unemployment (21%) and a third of its population falling into poverty. The growth of informal work emphasized the non-desired effects of the dual structure, with less than one quarter of the population covered by social security and receiving medical care in private-for-profit and non-profit organizations, and more than three quarters of the population being attended by public hospitals managed by ASSE (Arbulo et al. 2012). The economic situation exacerbated inequity before the reform since private providers received 74.6% of the resources while public services were allotted only 25.4% of the resources. Expenditure per affiliate was three times higher in the private sector (Ministerio de Salud Pública 2006). As described by the health minister, before the reform, the situation in Uruguay was the following:

Those who cannot pay have an assistance card and go to the public system. Workers contribute with their quotas to the DISSE (today FONASA) and go to the mutual system. Those who can afford the quota with their own means also go to the mutual system, and those who can pay more go to services provided by private insurance.

In 2004, for the first time since the transition to democracy in the mid-eighties, a left-to-center political coalition won the elections. President Tabaré Vázquez acquired a comfortable majority in both chambers to pass his legislative projects. The party manifesto of the *Frente Amplio* proposed the creation of a national integrated health system, aimed at UHC, and the use of general taxes to finance the health system with a stronger participation of the state in the regulation of the health sector. The two main reforms were the health reform and the income tax reform, which were supposed to take place at the same time. The health reform was approved in 2007, and the *Frente Amplio* won the elections in 2009 and again in 2014.



The reform in a nutshell

The main pieces of legislation were approved in 2007 with the creation of the National Health Fund and the National Health Insurance. Public, private, and third sector providers form the National Integrated Health System. The state regulates the way the system is financed, the contracts between the system and the providers, and the health program providers are supposed to implement in accordance with government policy.

Formal workers and employers contribute to the National Health Fund based on their salary level. The National Health Fund pays a per capita amount to health providers with certain incentives, while insured citizens have the option to change providers after being at least 3 years with one provider. Benefits are extended to the immediate relatives of the insured workers and are maintained after retirement. Uninsured citizens receive health services from the public provider (Fernández Galeano et al. 2015).

The government approved a health plan that established various health programs and activities. The reform encouraged a change of orientation from a system that was hospital centered, to a system that is oriented towards community health and preventive medicine based on the development of primary care. Some of the programs along those lines are the promotion of a reference doctor for families, increased compensation for doctors to prevent them from holding multiple jobs, and programs for specific groups like pregnant women and elderly individuals.

Main outcomes

According to the literature (Savedoff et al. 2012), countries must advance in two dimensions to achieve UHC: including more people, and reducing out-of-pocket payments. Tables 1 and 2 show progress with respect to the inclusion of citizens in the National Health Insurance and the reduction of out-of-pocket payments after the reform. Table 3 presents the organization of health provision and the reduction in the proportion of citizens that are not covered.

The number of citizens covered by the National Health Insurance increased substantially from 0.5 M before the reform to 2.5 M in 2016 in a country with a population of 3.4 M (Table 1). In 2016, the system covered more women than men and a

Table 1 Number of citizens included in the national health insurance

	2003	2007 (reform)	2008	2012	2016
Total	526.000	784.484	1.377.743	1.827.881	2.535.598
Men	–	56.6	53.1	50.1	47.0
Women	–	43.3	46.9	49.8	52.9
< 18	–	1.2	30.2	30.1	26.2
18–61	–	85.7	59.8	55.5	53.1
> 62	–	12.9	9.9	14.2	20.6

Source National Institute of Statistics Uruguay



Table 2 Distribution of health expenses in Uruguay

	Uruguay		
	Public	Private out-of-pocket	Private pre-paid
2002	28	22	12
2006	65	11	24
2010	62	18	20
2014	71	16	13

Source World Health Organization, Global Health Expenditure Database (2014)

Table 3 Percent of citizens attended by the public provider, private providers and uncovered

	2000	2004	2008	2012	2016
ASSE (public)	36.1	39.6	33.1	31.5	30.3
IAMC (private, third sector)	47.5	48.0	51.9	58.9	63.0
Other (private)			2.9	2.0	2.3
Not covered	11.9	8.2	12.0	7.5	4.3

Source National Institute of Statistics Uruguay

higher proportion of citizens under 18 (26.5%) or older than 62 (20.6%) as a consequence of the expansion of benefits to the relatives of insured individuals.

In socio-economic terms, Oreggioni (2015) reports for the period between 2006 and 2012, all the income deciles increased the proportion of citizens covered by the national health insurance: first, second, and third income deciles reached 16%, 40%, and 50%, respectively, and 4th to 8th deciles, corresponding to the middle and upper middle classes, increased from 54% to 68%.

According to WHO data (2014), out-of-pocket payments were reduced from 2002 to 2006. However, they increased in the period from 2006 to 2010. The levels of out-of-pocket payments were lower in Uruguay (16% in 2014) compared to other countries that have carried out health reforms like Brazil (25%) and Mexico (44%).

The majority of citizens contributing to the National Health Insurance prefer to receive health services through private or third sector providers (IAMC). These providers increased their share after the reform (Table 3) up to 63%, while the public provider decreased its quota from 36 to 30%. This behavior reflects an historical perception of the quality of services given by the public provider, which was recognized as a poor provider for poor people. Before the 2002 crises, nearly half of the population was covered by ASSE but this was not because citizens were upset with the “mutualistas” (Pribble 2013) but, more likely, because they were unemployed or worked in the informal sector (Setaro 2010). That is probably the reason why, once the new system was approved and the National Health Fund created, they opted for a “mutualista” again.

Economic growth after the reform and the income tax reform dramatically improved tax collections in Uruguay giving the state financial capacity to invest in



the improvement of the public health sector (Table 4). According to CEPAL, from 2004 to 2014, Uruguay reduced the informality in its economy by 13 points and multiplied tax collections by almost four.

Analysis, the politics of the reform

Agenda setting: why was universal health coverage prioritized?

In the 2004 elections, the *Frente Amplio*, a broad coalition of left-to-center political parties, unions, and associations, ended a century of bipartisanship with the *Colorado* and *Nacional* parties and won the national elections and the presidency.

According to a high official from the health ministry, *The 'integrated national health system' in the party manifesto transmitted the idea of universal health care, discarding the market mechanisms promoted by the World Bank in the nineties.* The *Frente Amplio* was supposed to be sensitive to the fact that a majority of people had suffered the economic crisis and the inequality in the distribution of health services. However, the party manifesto was ambiguous with respect to specific policy solutions on how to organize the provision of health services.

At the global level, the expansion of UHC was already one of the fundamental issues in health policy. For example, Brazil had made progress since 1988 (a special issue on Brazil was published by *The Lancet* in 2011) with a hybrid system and a significant growth in the number of hospital facilities, hospital beds, and ambulatory services at the local level (Costa and Vaitsman 2014). In 2003, Mexico introduced a national health insurance program called *Seguro Popular*, providing improved access to health services to 50 million previously excluded Mexicans (Frenk 2006; Knaul et al. 2012). The WHO was promoting UHC related reforms all over Latin America, Africa, and Asia.

Uruguay did not have a team of health technocrats trained abroad trying to impose a policy solution, nor was the reform the consequence of popular pressure. According to a political representative from the government: *The reform was driven primarily by local politicians in the government and the president, a doctor himself.* Tabaré Vázquez, who had been the mayor of Montevideo since 1990, brought a group of collaborators to the Health Ministry from the capital city. Daniel Olesker, an economist coming from the unions, was appointed as director of one of the most important units in the Ministry of Public Health, and later as the health minister.

Table 4 Income tax collection and informality in Uruguay (billion pesos)

	2000	2004	2008	2012	2014
Total collection	41.214	66.385	122.505	197.035	250.543
Informality Index (%)	37.2	40.7	32.9	25.6	23.5

Source General Direction Taxes Government of Uruguay and CEPAL



These people were the main architects of the reform together with a number of second-level technocrats.

Considering the number of attempts that had failed over the years, what conditions lead to the passage of the reform in 2007? According to various interviewees, the economic crisis in 2002 caused the issues of low health coverage and low quality of public services to be more visible. The *Frente Amplio* chose health reform as one of their main political goals at a time when the international community had been urging the expansion of UHC. These two major external shocks, the economic crisis at the turn of the century and the victory of the *Frente Amplio* in the elections of 2004, opened the political window for health reform in Uruguay.

Policy design: why did Uruguayan reform opt to reinforce the insurance model?

Uruguay opted to improve the insurance model that had been building during the last century rather than opting for a more radical change and create a national health service. However, the government gained institutional capacity to control the health system, integrating the providers in the national scheme and setting a health plan and health actions. The system was expected to improve equity through the expansion of the number of citizens included in the National Health Insurance and the improvement of the public services utilized by uninsured citizens.

However, in terms of provision, the system continued to be fragmented with a domination of private and third sector organizations that do not favor the value of solidarity. The promoters of the reform were very interested in the French model of the “*mutuelle de santé*,” as it offered the possibility to progressively integrate all the citizens in an equitable health system. They were also interested in the case of Spain because it reached a similar level in a decade, when other European countries needed a much longer period to scale up from social health insurance. According to a political representative from the government:

In the ministry, we paid much more attention to the French experience. We also looked at the cases of Belgium, Canada, and Israel. But, in terms of the political process, what called our attention was the Spanish case. We were attracted by how they managed to make the transition to national insurance in record time. At the same time, “We wanted to avoid the problems associated with the World Bank’s recommendations in Latin America.

In ideological terms, there was debate in the left as some of the unions were expecting that the government would *integrate the uninsured for free* (as stated by a high official from the ministry) and discard the market mechanisms in favor of hegemonic public funding through general tax revenues and direct public provision. These views were opposed by the political right, who were against any system that resembled what they called the “Cuban” option. As stated by a political representative from the *Colorado* party, *Here, a national health service is absolutely inviable from the perspective of the political culture of the country*. According to union representatives, the government lacked the courage to advance



towards a true transformation of the system. Other union representatives referred to the *lack of political will to integrate the rest of the people* in the national health insurance. For the most leftist members of the *Frente Amplio*, the outcome of the reform was not what they expected and *it felt like a defeat*.

The health minister believed the public provider could be competitive, and that it would progressively be the preferred provider of a majority of citizens. Ten years later, this is not the case. (Table 3). According to a public official in the ministry, the political discourse changed towards the idea that *using all the installed capacities favored a more efficient model of public services*. For the political opposition, the question for the government was *how to put the bell on the cat*, meaning that no one could successfully integrate the two systems. *No one can dissolve social security services and put everything in a public system, including health services for the army and the police*.

Therefore, the reform was not “groundbreaking” with respect to the past but it allowed a reset of the system and established new rules for the players who were used to self-regulation. Several interviewees justified the difficulties to radically change the system on the basis of a historical determinism. *Since 1910, the state reserved for itself the responsibility to take care of those who cannot pay for medical care. This early stamp determined the logic of ‘poor public assistance to poor people’ still holding today*.

For the private and third sector health organizations, their first concern was their financial stability after the economic crisis. *They were rather weak at the moment that the reform was introduced*, according to a health consultant. The majority of health organizations in Uruguay were small and they needed the business through the National Health Insurance. However, the government did not have a viable alternative for the middle classes through ASSE, the public provider. According to a political representative of the opposition *Colorado* party, *As a public enterprise, ASSE is ungovernable and it cannot successfully compete with private providers*.

Uruguay simultaneously passed the income tax reform, but the increase in government revenues was uncertain at the time. It was not politically feasible to ask the middle classes to finance the public provider through taxes and contribute to the national insurance for their own health care. According to a representative of the medical profession, *ASSE was and still is not popular. A majority of the population had the aspiration to have access to better private services*.

The content of the reform was the result of the political calculus of politicians. They wanted to appear as if they had achieved UHC and managed to create a more inclusive health system but, at the same time, they took a rather conservative approach to the organization of the health sector by contributing to finance private and third sector *mutualistas* as the main providers. This organizational arrangement was less risky than other options such as direct public service delivery and it satisfied all the stakeholders except for those who advocated for the inclusion of the uninsured poor for free. Furthermore, the government feared to raise the ire of the middle classes if the reform pushed the system to be more redistributive. All the interviewees agreed that there is a general preference to be attended by “mutualist” organizations. As expressed by one of the health professionals, *With more than two*



million people affiliated with the IAMCs, there is much resistance to any change on the side of those users, not to mention the resistance on the side of doctors.

Policy adoption: why was the reform not vetoed?

According to the literature on health reform in the US, presidential regimes experience more obstacles to have UHC reforms approved by the legislative branch of government than parliamentary regimes (Steinmo and Watts 1995; Blake and Adolino 2001; Béland et al. 2014). In the case of Uruguay, there are presidential elections, but the government does not function as a pure presidential system. The parliament is elected following a proportional representation formula, and the government works like a semi-presidential system. The electoral victory of *Frente Amplio* in 2004 gave the government a landslide majority in both chambers of the parliament, which made government reforms much more likely.

Compared to other Latin American countries, Uruguay has an institutionalized party system (Buquet et al. 1998). Political power is centralized and candidates depend on party leaders to be included in the electoral lists. These characteristics of political parties discourage disloyal behavior of political representatives and reinforce the power of elected presidents. According to a representative of the *Frente Amplio*, *party discipline was not an issue in the passage of the reform*. Even if some political representatives had to compromise their policy convictions, they opted to maximize their chances of reelection within the party.

The health reform did not encounter a significant political opposition from the public. Only some unions defended that health benefits were extended to historically excluded groups. However, other unions and the *Colorado* and *Nacional* political parties argued that extending the benefits to all the citizens implied an additional burden on formal workers.

Cultural norms about how policy decisions are formulated ultimately led the government to negotiate with professional medical associations, providers' organizations, and unions. Professional medical associations were divided into two groups, one in favor of the reform and another opposing it along the lines of the main pro-government and opposition political parties. However, the proposed reform was congruous with the interests of a majority of private and third sector organizations, since it was designed to respond to their concerns on financial sustainability.

Union representatives presented the interest groups of doctors as the key actors. They argued that *the government had to step on someone's toes. The toes were those of the business medical corporations; however, the government stepped on the breaks because business interests of doctors forced the government to back off*. For the most leftist members of the *Frente Amplio*, *The responsibility not to have advanced into more substantive changes with regard to the integrated national health insurance lies on the corporatist interests of doctors*. Similarly, *there was no way they were going to accept a national public service, because they would never give up their professional autonomy as doctors*. That is the reason why, according to some union representatives, *the government was wrong to negotiate with business interests and the medical profession. They passed the SNIS, but with a limited*



range. The main critiques did not come from the political opposition, the more conservative medical association, or from health providers, but from leftist groups and unions who understood that the government was weak in the face of private interest groups and not ambitious enough regarding poor excluded citizens.

Public sector organizational issues: how did they influence policy options?

The reform created the instruments that were necessary to manage the National Health Insurance, like the National Health Fund and an agency in charge of the contracts with private and third sector providers (the National Health Board, or JUNASA in its Spanish initials). The reform did not create ASSE, the public provider, which was preexisting, although the reform encouraged giving ASSE more autonomy to manage. For a majority of stakeholders, ASSE and the quality of health services provided to patients was the main organizational problem. As was repetitively asserted during interviews, *people who have the option to exit the public sector will do it*. Along the same lines, comments on the quality of the services provided by ASSE were very negative: *The quality of attention is bad, no minister or manager of the health care system receives attention there*.

Health policy reform was conditioned by the capacity of ASSE to deliver services. By its size, characteristics, and territorial expansion, ASSE is a key factor in health care provision in Uruguay. However, ASSE needs better infrastructure, equipment, and management of human resources, including meritocratic selection, differential compensation, and general rule-abiding by its professionals. For various government officials, the system was expected to evolve into a mix of public and private provision, with a more prominent role for the public sector. *It should no longer be the rear door of the system for uninsured citizens*. For the political right, *ASSE as a competitor is fiction*. There was a general feeling of failure with respect to ASSE's incapacity to change. But, even for those who were less confident in the capacities of ASSE, it has a role to perform: covering the one-third of the population that could not be assisted any other way. *It needs to keep taking care of poor people*. ASSE was also considered essential outside the capital.

The other major organizational problem affecting any policy is the ability of the state to collect taxes. This was seen as a major barrier in a country with a large part of the population working in the informal sector. The government expected that the inclusion of a substantial number of citizens in the National Health Insurance would make the system financially stronger, freeing public resources to invest in public facilities, equipment, and staff. This is what happened in the 10-year period after the reform was approved (Table 4). However, the increasing availability of public resources did not change the policy orientation of the reform.

In sum, the government was able to implement regulatory changes in the health sector, integrate the system, and improve the tax base. Uruguay included a very significant number of its citizens in the National Health Insurance, but it had more difficulties to change the organization of health provision and the reputation of the public provider.



Conclusions

Uruguay is a good example for countries experiencing difficulties with the quality of public health services, attempting to expand the number of citizens included in a National Health Insurance and to reduce the financial risk associated with health expenditures. The 2007 health reform improved the capacity of the state as a regulator of health finances, and as the principal coordinator in the contractual relations between the National Health Insurance and private and third sector providers. The state also increased its capacities to develop the programs that health providers should implement. Ten years after the reform, Uruguay has significantly increased the number of citizens included in the National Health Insurance and substantially reduced out-of-pocket payments. The reform has also amplified the share of the private and third sector providers with respect to the public provider but the changes in the way the National Health Insurance is financed, in addition to the tax reform, have increased the financial capacities of the state to invest in the public health sector.

The analysis of health reform in Uruguay confirms some of the key propositions from the policy change literature. First, the reform introduced new dynamics in the management of the health system, particularly in the coordination of health policy and the financing of private and third sector providers. But change was rather incremental making it more likely that reforms were approved as they did not pose a threat to the existing health services. The government opted for a compromise that was acceptable to opposition political parties, health interests, and the middle classes, but created frustration among the more leftist members of the *Frente Amplio*. From this perspective, this study adds another case of incremental change and confirms that abrupt change is the exception (Lindblom 1959; Baumgartner and Jones 1993; Sabatier and Jenkins-Smith 1999; Sabatier and Weible 2007).

Second, we could identify external events producing a shock that was necessary, but not sufficient, for a more radical policy change (Birkland 2006). The political window of health reform opened in Uruguay with the economic crisis at the turn of the century and with an electoral change that brought to the government a coalition of left-of-center political parties and unions. The crisis made more visible the risk of not having adequate health protection for the middle classes and the new government appeared to care about health public services and extending access to the lower-middle classes and the poor.

Third, this study confirms how past policies establishing an employer-based health insurance model develop specific expectations about how health insurance should be provided and act as a barrier to moving toward a government insurance program based on public provision (Martínez Franzoni and Sánchez Ancochea 2016). These processes confirm the weight of historical legacies and path dependency theories (Wilsford 1994; Pierson 2004).

More specifically, the analysis of the Uruguayan case adds a more nuanced vision of power struggles and government–society relations in the context of health reform. First, the state orientation of Uruguay and the progressive



investment in the public provider pave the way for a stronger public control. The historical weaknesses of public health providers make any alternative that does not count with private and third sector organizations less likely. However, as the National Health Insurance, private and third sector providers become financially stable, the government can dedicate a bigger share to infrastructure, equipment, and personnel in the public provider increasing the probability that it becomes a real competitor and an attractive alternative for middle classes.

Second, as advanced by Immergut in 1992, medical and professional interests will oppose any reforms that pose a threat to the professional autonomy of doctors or to the economic interests of private health organizations, but governments can overcome this opposition. According to this study, one way is making a clear statement that the reform builds on preexisting health organizations and contributes to their financial stability. The trade-off is, however, that empowering professional and economic health groups, governments run the risk to become even more dependent on external providers and to strengthen the position of the medical profession in future rounds of policy changes.

Third, in Uruguay like in other Latin American countries, trade unions are not very strong in the private sector but they have more presence in the public sector and exercise influence at the macro political level. However, in presidential systems like Uruguay, where the government can acquire a solid majority in the parliament, and political representatives need the support of the political party to be reelected, the government can reduce the political opposition. The investment in the public sector and the improvement of the working conditions in the public provider also reduce the opposition to reforms by the unions.

The results of this study are contingent on the national context in which this investigation took place. In other countries, citizens may have different images of the public, private-for-profit, and third sector health providers, depending on the public service culture and their previous experience. Other features of national context, such as political culture and public administration tradition may also affect their preferences on health insurance.

The analysis of health reforms in low- and middle-income countries requires further research. The extension of benefits to various groups of population should translate into better health outcomes. In the case of Uruguay, the public provider needs to be monitored with regard to its general evolution, the funding it receives, and the quality of the services it delivers. According to the minister that promoted the reform, there would be a moment when citizens would freely choose the public provider because it would be competitive. Another important outcome to be monitored is the blurring of boundaries between citizens included and not included in the National Health Insurance.

With regard to the study of health reforms and the policy process, we do not know yet whether incremental reforms reduce or increase the opposition to more abrupt policy changes. We could expect that political representatives, the medical profession, private, and third sector health organizations will adapt to a new context with more open and transparent competitive tendering where the public provider has improved its reputation and the system becomes truly universalistic in terms of both access and quality.



Appendix

See Table 5.

Table 5 List of people interviewed (2012–2015)

#	Position	Organization	Date of interview
1	High official	Health Ministry	July 2012/October 2014
2	Member of Parliament	Colorado Political Party	July 2012/October 2014
3	Health expert	Private health consultant	July 2012
4	Nurse	Public hospital	August 2012
5	Doctor	Public Hospital and Private Clinic	August 2012
6	Member of Parliament	Nacional Political Party	June 2013
5	President	Doctors association	August 2013
7	General manager	IAMC Association	September 2013
8	Union leader	Workers Union	September 2013
9	Former union leader	Workers Union	September 2013
10	President	Patients association	October 2013
11	Dean	Medicine school	October 2013
12	Vice-President	Private insurance association	September 2013
13	Director	Public hospital	October 2013/October 2014
14	Former director ASSE	Public provider	May 2015
15	Former vice-minister	Health Ministry	May 2015
16	Former health minister	Health Ministry	May 2016

References

- Antía, F., F. Carneiro, M. Castillo, G. Fuentes, C. Midaglia, and B. Villegas. 2017. *Orígenes del bienestar en Uruguay: explicando el Universalismo Estratificado*. Working Paper 01/2017. Instituto de Ciencia Política.
- Arbulo, V., J. Pagano, G. Rak, and L. Rivas. 2012. *El camino hacia la Cobertura Universal en Uruguay: evaluación y revisión del financiamiento del sistema de salud uruguayo*. Montevideo: PAHO.
- Banco Interamericano de Desarrollo. 2006. *Universalismo básico: una nueva política social para América Latina*. Washington, DC: Banco Interamericano de Desarrollo.
- Barrientos, A. 2004. Latin America: Towards a liberal-informal welfare regime. In *Insecurity and welfare regimes in Asia, Africa and Latin America*, ed. I. Gough, G. Wood, A. Barrientos, P. Bevan, P. David, and G. Room. Cambridge: Cambridge University Press.
- Barrientos, A. 2009. Labour market and the (hyphenated) welfare regime in Latin America. *Economy and Society* 38 (1): 87–108.
- Baumgartner, F.R., and B.D. Jones. 1993. *Agendas and instability in American politics*. Chicago, IL: University of Chicago Press.
- Béland, D., P. Rocco, and A. Waddan. 2014. Implementing health care reform in the United States: Inter-governmental politics and the dilemmas of institutional design. *Health Policy* 116 (1): 51–60.
- Birkland, T.A. 2006. *Lessons of disaster: Policy change after catastrophic events*. Washington, DC: Georgetown University Press.
- Blake, C.H., and J.R. Adolino. 2001. The enactment of national health insurance: A boolean analysis of twenty advanced countries. *Journal of Health Politics, Policy and Law* 26 (4): 679–708.
- Brewer, G.D., and P. de Leon. 1983. *The foundations of policy analysis*. Pacific Grove, CA: Brooks/Cole.



- Buquet, D., D. Chasquetti, and J.A. Moraes. 1998. *Fragmentación política y gobierno en Uruguay. ¿Un enfermo imaginario?*. Montevideo: Instituto de Ciencia Política.
- Costa, N.R., and J. Vaitsman. 2014. Universalization and privatization: How policy analysis can help understand the development of Brazil's health system. *Journal of Comparative Policy Analysis* 16 (5): 441–456.
- Fernández, M., E. Levkovitz, and D. Olesker (eds.). 2015. *Economía, Política y Economía Política del Acceso y la Cobertura Universal de Salud en Uruguay*. Montevideo: Organización Panamericana de la Salud.
- Filgueira, F. 1998. El nuevo modelo de prestaciones sociales en América Latina: Residualismo y ciudadanía estratificada. In *Ciudadanía y política social*, ed. B. Roberts. Flasco: San José.
- Fox, A.M., and M.R. Reich. 2015. The politics of universal health coverage in low and middle-income countries: A framework for evaluation and action. *Journal of Health Politics, Policy and Law* 40 (5): 1019–1056.
- Frenk, J. 2006. Bridging the divide: Global lessons from evidence-based health policy in Mexico. *Lancet* 368 (9539): 954–961.
- Fuentes, G. 2013. *La creación del Sistema Nacional Integrado de Salud en Uruguay (2005–2012): impulso reformista con freno desde los puntos y actores de veto*. Doctoral Thesis. Universidad Complutense de Madrid.
- Fuentes, G. 2015. Actores, intereses y alianzas de cara a la segunda etapa de implementación del SNIS: cambio institucional gradual y posibles escenarios y orientaciones de cambio. In *Economía, política y economía política para el acceso y la cobertura universal en salud en Uruguay*, ed. G. Fernández, E. Levkovitz, and D. Olesker. Montevideo: Organización Panamericana de la Salud.
- Fukuyama, F. 2004. *State-building: Governance and world order in the twenty-first century*. Ithaca, NY: Cornell University Press.
- Holmes, D. 2012. Margaret Chan: Committed to universal health coverage. *The Lancet* 380 (9845): 879.
- Huber, E., and J. Stephens. 2001. *Development and crisis of the welfare state*. Chicago, IL: Chicago University Press.
- Immergut, E. 1992. *Health politics: Interests and institutions in Western Europe*. New York: Cambridge University Press.
- Iversen, T., and D. Soskice. 2006. Electoral institutions, parties and the politics of class: Why some democracies distribute more than others. *American Political Science Review* 100 (2): 165–181.
- Jones, C.O. 1970. *An Introduction to the Study of Public Policy*. Belmont, CA: Wadsworth.
- Kingdon, J. 1995. *Agendas, alternatives and public policies*. Amsterdam: Longman.
- Knaul, F., E.M. González-Pier, O. Gómez-Dante, et al. 2012. The Quest for universal health coverage: Achieving social protection for all in Mexico. *Lancet* 380 (9849): 1259–1279.
- Lakin, J.M. 2010. The end of insurance? Mexico's Seguro popular, 2001–2007. *Journal of Health Politics, Policy and Law* 35 (3): 313–352.
- Levitsky, S., and M.V. Murillo. 2009. Variation in Institutional Strength. *Annual Review of Political Science* 12: 115–133.
- Lindblom, C.E. 1959. The science of “Muddling Through”. *Public Administration Review* 19 (2): 79–88.
- Martínez Franzoni, J. 2008. Welfare regimes in Latin America capturing constellations of markets, families, and policies. *Latin American Politics and Society* 50 (2): 67–100.
- Martínez Franzoni, J., and F. Filgueira. 2002. Paradigmas globales y filtros domésticos: Las reformas administrativas de las políticas sociales en América Latina. *Revista de Ciencias Económicas* 18 (2): 191–215.
- Martínez Franzoni, J., and D. Sánchez Ancochea. 2016. *The quest for universal social policy in the south: Actors. Ideas and Architectures*: Cambridge University Press.
- Martínez Franzoni, J., M. Molyneux, and D. Sánchez-Ancochea. 2009. Latin American capitalism: Economic and social policy in transition. *Economy and Society* 38 (1): 1–16.
- Ministerio de Salud Pública. 2006. *Cuentas Nacionales de Salud*. Montevideo: Ministerio de Salud Pública.
- Molina, O., and M. Rhodes. 2007. The political economy of adjustment in mixed market economies: A study of Spain and Italy. In *Beyond varieties of capitalism: Contradictions, complementarities and change*, ed. B. Hancke, M. Rhodes, and M. Thatcher. Oxford: Oxford University Press.
- Nelson, J. 2004. The politics of health sector reforms: Cross-national comparisons. In *Crucial needs, weak incentives: Social sector reform, democratization, and globalization in Latin America*, ed. R. Kaufman and J. Nelson. Washington, DC: Woodrow Wilson Center Press.



- Oreggioni, I. 2015. El camino hacia la cobertura universal en Uruguay: cambios en el financiamiento del sistema de salud uruguayo. In *Economía, Política y Economía Política del Acceso y la Cobertura Universal de Salud en Uruguay*, ed. M. Fernández, E. Levcovitz, and D. Olesker. Montevideo: Organización Panamericana de la Salud.
- Pierson, P. 2004. *Politics in time: History, institutions, and social analysis*. Princeton, NJ: Princeton University Press.
- Pribble, J. 2013. *Welfare and Party Politics in Latin America*. Cambridge: Cambridge University Press.
- Pontusson, J. 2005. Varieties and commonalities of capitalism. In *Varieties of capitalism, varieties of approaches*, ed. D. Coates. London: Palgrave Macmillan.
- Roberts, M.J., W. Hsiao, P. Berman, and M.R. Reich. 2004. *Getting health reform right: A guide to improving performance and equity*. New York: Oxford University Press.
- Sabatier, P.A., and H.C. Jenkins-Smith. 1999. The advocacy coalition framework: An assessment. In *Theories of the policy process*, ed. Paul A. Sabatier, 117–168. Boulder: Westview Press.
- Sabatier, P.A., and C. Weible. 2007. The advocacy coalition framework: Innovations and clarifications. In *Theories of the policy process*, ed. Paul A. Sabatier, 189–222. Boulder: Westview Press.
- Savedoff, W.D., D. de Ferranti, A.L. Smith, and V. Fan. 2012. Political and economic features of the transition to universal health coverage. *Lancet* 380 (9845): 924–932.
- Setaro, M. 2010. La creación del Sistema Nacional Integrado de Salud y el nuevo Estado para la performance. In *Reforma del Estado y Políticas Públicas durante la Administración Vázquez: acumulaciones, conflictos y desafíos*, ed. N. Mancebo. CLACSO-ICP: Montevideo.
- Sheahan, J. 2002. Alternative models of capitalism in Latin America. In *Models of capitalism: Lessons for Latin America*, ed. E. Huber. University Park, PN: Pennsylvania State University Press.
- Steinmo, S., and J. Watts. 1995. It's the institutions, stupid! Why comprehensive national health insurance always Fails in America. *Journal of Health Politics, Policy and Law* 20 (2): 329–372.
- Stone, D.A. 1989. Causal stories and the formation of policy agendas. *Political Science Quarterly* 104 (2): 281–300.
- Tsebelis, G. 2002. *Veto players. How political institutions work*. Princeton NJ: Princeton University Press.
- Weyland, K. 2005. Theories of policy diffusion: Lessons from Latin American pension reform. *World Politics* 57 (2): 262–295.
- Wilsford, D. 1994. Path dependency or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Public Policy* 14 (3): 251–283.
- World Bank. 2004. *Inequality in Latin America: Breaking with history?*. Washington, DC: World Bank.
- World Health Organization. 2014. *Global health expenditure database*. Geneva: WHO.

