THE ROLES OF VALUES IN HEALTH SYSTEMS

UNDERSTANDING THE ROLE OF VALUES IN LATIN AMERICAN HEALTH SYSTEMS

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Lay abstract

Values are important at all stages of the policy process. However, it is often not clear how they are incorporated into policy decision-making about health systems. In Latin America, the study of the role of values and how they inform the prioritization, development, and implementation of policies in different contexts, is an emerging field. This dissertation addresses key gaps in understanding by: 1) developing a framework, which can be used as a tool by policymakers and stakeholders to identify which values support or compete with their initiatives, how to make initiatives more socially supported, and how to focus policies according to the goals of the government and the health system; 2) analyzing how, based on media reports and governmental and non-governmental documents, values have informed two health system financing decisions in each of Chile and Colombia; and 3) examining the views and experiences of policymakers and stakeholders about how and why values were used in decision-making processes related to the same two policy decisions in each of Chile and Colombia.

Abstract

It is often not clear how values are incorporated into policy decision-making about health systems. This is perhaps not surprising given the complexity of decision-making about health systems, the wide range of values prioritized (and advocated for) by different stakeholders, the broad array of sources for or mechanisms available to identify values, and the many ways in which values can drive policy decisions, as well as the reality that policymakers often do not want to be explicit about the values used in policy decision-making process. Using synthesis and qualitative research methods, this dissertation investigates the role of values in policy decision-making about health system financing in Latin America and contributes to the understanding of this field by providing insights for policy and research. The dissertation moves from a general and descriptive focus to a specific and explanatory focus. First, a critical interpretive synthesis was used to develop a theoretical framework that identifies how and under what conditions values inform policy decision-making about health system financing in Latin American countries. In chapters 3 and 4, the focus narrows by using an embedded multiple-case study design that analyzes two specific decisions in each of Chile and Colombia. Frameworks that explain government agenda setting and policy development and the theoretical framework developed in chapter 2, are used to analyze these decisions. The second study (chapter 3) is a discourse analysis which qualitatively assess how declared values inform the four decisions in Chile and Colombia. The third study (chapter 4), draws on in-depth qualitative interviews to understand how and why policymakers and stakeholders use declared and undeclared values in those four decisions in Chile and Colombia.

The research chapters build on each other and make substantive, methodological and theoretical contributions. The dissertation provides a rich understanding of the roles of values in health system financing decisions through a critical interpretive synthesis and two qualitative

studies, adding to the evidence base that stakeholders and policymakers can draw from when making or shaping policy decisions. These studies collectively build an understanding about what values inform the health policy process in Latin America, how those values work, under what conditions they come to be influential, how they are applied in real decisions, and why policymakers and stakeholders perceive that values play a role in real decisions. All of this evidence has contributed to the development a new theoretical framework about the roles of values in health systems.

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Table of contents

Introduction 1

Identifying values in the health policy decision-making processes about health-system financing in Latin America: A critical interpretive synthesis ....**Error! Bookmark not defined.**18

Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A discourse analysis 111

Understanding the role of values in the health policy decision-making processes about health-system financing in Chile and Colombia: A multiple-case embedded study 179

Conclusions 250

List of figures

Chapter 2 - Identifying values in the health policy decision-making processes about health-system financing in Latin America: A critical interpretive synthesis

- Figure 1. Characteristics of studies included by periods of time……………......…...…56
- Figure 2. Number of times each country was specifically addressed………….........…57
- Figure 3. Prisma Chart…………………………………..………..……………...…58
- Figure 4. Graphical representation of the framework……………………………………59

Chapter 3 - Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A discourse analysis

- Figure 1. Overview of multiple case embedded design..……………………........…...155
- Figure 2. Timeline of the principal events in both embedded decisions in Chile...……156
- Figure 3. Timeline of the principal events in both embedded decisions in Colombia…157

Chapter 4 - Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A multiple-case embedded study

- Figure 1. Overview of multiple case embedded design………………………………..215
- Figure 2. Timeline of the principal events in both embedded decisions in Chile...……216
- Figure 3. Timeline of the principal events in both embedded decisions in Colombia…217

List of tables

Chapter 1 – Introduction

- Table 1. Overview of the scope and principal contributions of the studies…........…...…6

Chapter 2 - Identifying values in the health policy decision-making processes about health-system financing in Latin America: A Critical Interpretive Synthesis

- Table 1. Characteristics of all included papers and purposively sampled……………….60
- Table 2. Categories of values and how they are used……………………………………61
- Table 3. The conditions in which values are used in different stages of the policy process ……………………………………………………………………………..64

Chapter 3 - Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A discourse analysis

- Table 1. Literature search strategy…...……………………………………........…...158
- Table 2. Type of documents reviewed according to the country and the decision.….…159
- Table 3. How values were used in each embedded decision in Chile…………………..…160
- Table 4. How values were used in each embedded decision in Colombia…………..…164

Chapter 4 - Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A multiple-case embedded study

- Table 1. Summary of participants by role and country……….……………….....……218
- Table 2. How values were used in each embedded decision in Chile…………………..…219
- Table 3. How values were used in each embedded decision in Colombia…………..…222

List of appendices

Chapter 2 - Identifying values in the health policy decision-making processes about health-system financing in Latin America: A Critical Interpretive Synthesis

- Appendix 1. Literature search strategy……………………………………………………..70
- Appendix 2. List and reasons for articles excluded……………………………………...71
- Appendix 3. Conceptual mapping according Kingdon's Framework and 3Is Framework…………………………………………………………………………...84
- Appendix 4. Characteristics of all papers included……………………………………...87
- Appendix 5. Values identified in papers reviewed……………………………….…106

Chapter 3 - Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A discourse analysis

- Appendix 1. Sources and websites consulted………………………………………….168
- Appendix 2: Summary of factors playing a role in agenda setting and policy development for the health-system financing decisions in Chile…………………………………….170
- Appendix 3: Summary of factors playing a role in agenda setting and policy development for the health-system financing decisions in Colombia………………………………..173

Chapter 4 - Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A multiple-case embedded study

- Appendix 1. Summary of factors playing a role in agenda setting and policy development for both embedded decisions in Chile……………………………………………………..225
- Appendix 2. Summary of factors playing a role in agenda setting and policy development for both embedded decisions in Colombia……………………………………………..228
- Appendix 3. Recruitment email…………………………………….......…......….232
- Appendix 4. Letter of invitation to participate………….………….………...….…233
- Appendix 5. Information sheet and consent form -McMaster University……………...235

- Appendix 6. Ethical Approval Hamilton Integrated Research Ethical Board - HiREB……………………..…………………………………………………...……..…...239
- Appendix 7. Ethical Approval by the Ethical Committee of the School of Medicine - University of Antioquia (Colombia)………………………………………………….....240
- Appendix 8. Ethical approval by Ethical Committee Universidad Adolfo Ibañez (Chile)…………………………………………………………………………….......242
- Appendix 9. Interview Guide…………………...…………….....………………..…....244
- Appendix 10. Open coding and categories….…..…………………………………..…..249

List of abbreviations

3I+E – Institutions, interests, ideas, and external factors

AUGE – Acceso Universal de Garantías Explícitas (Universal Plan of Explicit Entitlements)

CIS – Critical interpretive synthesis

EPS – Entidad Promotora de Salud (Health Insurance Company)

FONASA – Fondo Nacional de Salud (National Health Insurance Fund)

FOSYGA – Fondo de Solidaridad y Garantías (Solidarity and Guarantees Fund)

GES – Garantías Explícitas en Salud (Explicit Health Guarantees)

HiREB – Hamilton Integrated Research Ethics Board in Hamilton, Ontario, Canada

ICESCR – The International Covenant on Economic, Social and Cultural Rights

IDB – Inter-American Development Bank

IETS – Instituto de Evaluación de Tecnologías en Salud (Health Technology Assessment Institute)

IMF – International Monetary Fund

ISAPRES – Instituciones de Salud Previsional (Private health insurance institutions)

LMICs – Low- and middle-income countries

MDG – Millennium Development Goals

MeSH – Medical Subject Heading

NGO´s – Non-Governmental Organizations

OOPS – Out-of-pocket spending

PAHO – The Pan-American Health Organization

PHC – Primary Health Care

PI – Principal investigator

POS – Plan Obligatorio de Salud (Health Benefits Plan)

UN – United Nations

UPC – Unidad de Pago por Capitación (Capitation Unit)

WB – World Bank

WHO – World Health Organization

Declaration of academic achievement

This dissertation presents three original scientific contributions (chapters 2-4), along with introductory and concluding chapters (chapters 1 and 5). Each of the chapters in this dissertation is co-authored, and I, Marcela Velez, am the lead author for each. Details of specific contributions are provided in the preface to each individual chapter. Overall, I conceived of each chapter with my supervisor, Dr. Michael G. Wilson, and with inputs from members of my supervisory committee, Dr. John Lavis and Dr. Julia Abelson. I completed all data collection and analysis for each chapter. Finally, I drafted all chapters, and each co-author provided feedback that was incorporated into subsequent revisions.

Chapter 1-Introduction

This chapter introduces a Ph.D. dissertation that consists of three original research chapters (chapters 2-4). The introduction is structured to present, in the first part, an overview of current evidence about the role of values in health systems, followed by the overarching aims, rationale and approaches for each of the individual studies in this thesis. In the second part, I conclude the chapter with an overview of the substantive, methodological and theoretical contributions addressed by the dissertation.

Why focus on values about health system financing decisions in Latin America

Every health system in the world embodies values that guide health policy decisions.(1–3) These values are essential at all stages of the policy process, ranging from the prioritization of some issues over others on a government's agenda to the development of policy options to address an issue and the implementation of selected policy options. When governments or institutions more generally set agendas and develop and implement policies, they also legitimize and promote certain values over others, making decisions about health systems value-laden.(4)

The concept of values does not have a precise definition or meaning. In the dictionary the word value appears with different meanings, with one defining values as "*the principles or standards of behaviour; one's judgment of what is important in life*".(5) To fit with the policy focus of this research, I have selected the following definition of values: "*values are principles, or criteria, for selecting what are good (or better, or best) among objects, actions, ways of life, and*

social and political institutions and structures. Values operate at the level of individuals, of institutions, and of entire societies".(6)

Although values underpin the goals pursued in health systems and often the means for achieving them, including how health systems and particular health policies benefit the population, it is often not clear how values are incorporated into policy decision-making about health systems. This is perhaps not surprising given the complexity of decision-making about health systems, the wide range of values prioritized (and advocated for) by different stakeholders, the broad array of sources for or mechanisms available to identify values, and the many ways in which values can drive policy decisions, as well as the reality that policymakers often do not want to be explicit about the values used in policy decision-making process.(7)

Yet clarity may be all the more necessary in the resource-constrained health systems of low- and middle-income countries (LMICs), where the values guiding how to get cost-effective treatments to those who need them, and to achieve better health status in their populations, can have particularly large and direct impacts.(1) Moreover, values are particularly important for decisions about health-system financing in LMICs. For example, LMICs that have implemented for-profit private health insurance face more challenging decisions, given that they have to balance the for-profit interest of private actors and the need achieving public health goals and improving the health of populations. Across LMICs, Latin American countries have the highest average percentage of for-profit private health insurance in the world. According to Pettigrew & Mathauer, Latin America has the greatest proportion of countries with percentage of voluntary health insurance higher than 5% over the 18 year period of the study (1995-2012).(8)

Regarding the field of studying values in health policy decision-making in Latin America this is an emerging field, and there is a paucity of evidence about the role of values and how they

inform the prioritization, development, and implementation of policies in different contexts. Only a few examples of research on values in health systems and or in health-system reforms or changes can be found in the literature. For example, Clark has studied the meanings of universal healthcare in Latin America, which can be considered a value underpinning many health systems.(9) Lavados & Gajardo have studied the "principle of justice" as it relates to the central objectives of the reform in Chile under Plan AUGE.(10) Pontes et al. have studied how the principles of the Brazilian Unified Health System are incorporated into ethical-doctrinal and organizational principles among health professionals.(11)

However, Latin America provides a vibrant context for studying the role of values given its many recent political transformations. In the last 40 years, many countries in the region have moved from dictatorships to democracies, democratic governments have been run by right-wing, centrist and left-wing parties and there has been unequal economic growth within and across countries. At the end of the 1980s and 90s, virtually all countries in Latin America began the process of reforming their health systems according to the ideas promoted by the World Bank (WB) and the Inter-American Development Bank (IDB).(12–18) As a consequence, most of the countries introduced private insurance in their health systems (which were the dominant values espoused by the WB and IDB), with Argentina, Brazil, Chile, Colombia, Mexico and Uruguay as the countries with a stronger presence of private health insurance.(19) Moreover, with the different role of public and private finance and the different values driving those approaches to financing systems, focusing on health-system financing decisions (i.e., how is the money raised? how are funds pooled? and how are services paid for?) offers a rich area of inquiry about the role of values in policy decision-making about Latin American health systems. Decisions in this area typically

need to balance more (or more visible and consequential) competing values than those about governance or delivery arrangements.

However, there is little evidence about how such dynamic contexts influence the values chosen to guide policy decision-making about both health systems financing and arrangements. Indeed, in my preliminary search for this synthesis, to the best of my knowledge no systematic review has specifically focused on values in Latin American health systems.

Among all the Latin American countries that introduced private for-profit health insurance, several authors have identified Chile and Colombia not only as the pioneers in this area, but also as the countries with more extensive implementation of these policies.(20–23) Interestingly, in the last decade, both countries have developed and implemented divergent policies to regulate the participation of for-profit insurance companies and to correct failures of health-system financing in their countries.

This context, with the history of political transformations, the presence of for-profit insurance companies, and the efforts of policymakers to accomplish the goals of health systems through reforms to how they are financed, offers a unique opportunity to assess the roles of values in policy decision-making about health-system financing.(22–24) Such an assessment will enrich our current understanding about the role of values in decision-making in LMIC that have implemented for-profit private health insurance.

To begin this contribution, this thesis focuses first (in chapter 2) on using a critical interpretive synthesis (CIS) approach to develop a broader understanding of what, how, and under what conditions values inform decisions about health-system financing in Latin America. The findings of the CIS explain how different values are taken into consideration and inform policy decision-making. I propose a framework that integrates different categories of social and political

values, and how those values play a role in the agenda-setting, policy development and policy implementation of health-system financing decisions in Latin America.

In the chapters 3 and 4, the focus narrows by using an embedded multiple-case study design that analyzes two specific decisions in a priority health policy domain (health-system financing) for two Latin American countries (Chile and Colombia). The studies ask: 1) what declared and undeclared values are important in the decision-making processes that crafted these policies?; 2) how do values inform these decisions?; 3) under what conditions were values influential; and 4) why are some values incorporated in these processes about health-system financing in Chile and Colombia? (see Table 1 for an overview of the scope and principal contributions of the studies).

Table 1. Overview of the scope and principal contributions of the studies

Aspect	Study 1 (chapter 2)	Study 2 (chapter 3)	Study 3 (chapter 4)
Questions addressed	1) What values inform decisions about health system financing? 2) How do values inform these decisions? 3) Under what conditions values are influential?	1) What socially and politically declared values are important in making decisions about health-system financing? 2) How do values inform these decisions? 3) Under what conditions were values influential?	1) What declared and undeclared values are important in the decision-making processes about health-system financing? 2) How do values inform these decisions? 3) Why are some values incorporated in these processes?
Design	• Critical interpretive synthesis	– Multiple case embedded-design – Discourse analysis	– Multiple case embedded-design – In-depth semi-structured interviews
Scope	• Health-system financing in Latin America	• Two health-system financing policy decisions in each of Chile and Colombia	• Two health-system financing policy decisions in each of Chile and Colombia
Data source(s)	• Scholarly literature	• Policy documents and media	• Views and experiences of policymakers and stakeholders
Type of values studied	• Declared values	• Declared values	• Declared and undeclared values
Connections between studies	• Developed a framework used as an analytical tool in studies 2 and 3	• Analyzed data using the framework developed in study 1 • Identified and explained the role of declared values to inform analysis in study 3	• Analyzed data using the framework developed in study 1 • Complemented findings from study 2 about declared values with findings about undeclared values • Identified reasons for why declared values identified in study 2 were used
Substantive contributions	• Provides a new theoretical framework of how and under what conditions values	• Provides the first analysis of how declared values have informed two health-system financing	• Enriches the discourse analysis presented in study 2 to provide first-hand insights from policymakers and stakeholders about which declared and

	influence the policy process on for health system-financing decisions in Latin America	decisions in each of Chile and Colombia	undeclared values were prioritized in the policy decisions and how and why they were used
Methodological contributions	• Presents an approach for the development of a theoretical framework through a critical interpretive synthesis in a nascent area of study, where the available literature is sparse and methodologically diverse	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, and provides explanation of what values influenced those decisions, as well as how they were influential •	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, enriches the findings of study 2 by identifying undeclared values and interpretations of how values influence the four decisions, and provides the opportunity to explore why some values are incorporated in these policy processes
Theoretical contributions	• Identifies four categories of social and political values playing different roles in the policy development process about health system financing in Latin America, and four conditions under which values influence decision-making in this area	• Identifies what declared values influenced two policy decisions about health-system financing in Chile and Colombia and how those values played a role • Proposes that values entrenched through large structural reforms are central to shaping the many incremental changes made to health systems in subsequent years or decades	• Provides explanations of how and why some values influenced the four decisions, and proposes that policymakers only consider a small set of prioritized and often competing values to simplify the complex interplay of values influencing a particular decision

The policy decisions from each country included one decision within 10 years of when data were collected (i.e., since 2007) and another policy decision implemented within two years of data collection (i.e., since 2015). For the first decision in Chile, I selected the development and implementation of the Universal Plan of Explicit Entitlements (AUGE or GES plan), which is a universal care plan designed to make medical coverage available to all Chilean citizens suffering from one of a specified, but growing list of diseases (80 at present). For the second decision, I selected the approval of a law mandating universal coverage of treatments for high-cost diseases (known as Ricarte Soto Law), which provides financial protection for treatments associated with specific high-cost diseases to all citizens regardless of health-system affiliation or socioeconomic status. For the first decision in Colombia, I selected the declaration of health as a fundamental right which implies a change in the notion of health as a public service (first with the rule T-760 and after with the Statutory Law). For the second decision, I selected the mechanism established by the Health Ministry to explicitly exclude technologies which cannot be funded within the available resources of the public health system.

The focus of chapters 3 and 4 are complementary. In chapter 3 the focus is on understanding the role of declared values identified from documentary resources using a discourse analysis. The discourse analysis then complements chapter 4 which focuses on developing an understanding, based on key-informant interviews, of what declared and undeclared values are important in the policy process, how policymakers use those undeclared values and why some values are (and others not) incorporated into policy decision-making about health-system financing in Colombia and Chile.

Finally, chapter 5 provides reflections and conclusions based on the findings from each of the three studies. Specifically, it provides an overview of the principal findings of the thesis, a summary of the key strengths and potential limitations and implications. The implication provides a reflection on how the studies individually and collectively offer substantive, methodological and inter-disciplinary learnings.

Substantive, methodological and theoretical contributions of the dissertation

The understanding of the roles of values in decision-making, and particularly in Latin American health systems, is an emergent field of study. To the best of our knowledge, no existing studies have focused on understanding what values are used in the decision-making about health system financing in Latin American, how they play a role in the decision-making process, under what conditions values become influential, or why policymakers and stakeholders prioritize some values over others in policy decisions.

Substantively, the dissertation provides an in-depth understanding of the roles of values in health-system financing decisions using a mix of synthesized and qualitative evidence. The CIS in chapter 2 incorporates a broad range of systematically and transparently synthesized documents to develop the theoretical framework about the roles of social and political values in government agenda setting, policy development and implementation of health system-financing decisions. Chapter 3 presents a discourse analysis of how declared values have informed two health-system financing decisions in each of Chile and Colombia. In chapter 4, the findings from the discourse analysis are enriched through a qualitative analysis of key informant interviews about "how" and "why"

policymakers and stakeholders in Chile and Colombia perceive the role of declared and undeclared values in those four decisions.

The methodologies selected in this thesis aim to achieve broad as well as deep understandings of the role of values in decision-making about health-system financing in Latin American countries by moving from a general and descriptive focus to a specific and explanatory focus. First, a critical interpretive synthesis was used to develop a theoretical framework that identifies how and under what conditions values inform policy decision-making about health system financing in Latin American countries. Moving to a narrower and specific context, chapters 3 and 4 draws on established analytical frameworks derived from the political science literature (Kingdon's agenda setting framework, and the 3I+E framework that explains policy development and implementations decisions), but they are used in a novel way by combining them with the newly developed values framework from chapter 2.(25)

I combine a multiple-case embedded methodology with a discourse analysis of media and public documents in chapter 3 and with in-depth interviews with key informants in chapter 4. The combination of both methodologies strengthens the findings in chapters 3 and 4 as it allows for a common thread through both chapters by focusing on the same countries and decisions. Moreover, it allows for rich comparisons within and between countries in each of the studies, as well as across the two studies to better understand the role of declared values (in chapter 3) and both declared and undeclared values (in chapter 4) and to compare what is stated in policy documents to what policymakers and stakeholders shared in interview (including their insights about how values were used to inform decisions).

Lastly, this dissertation provides theoretical contributions to the understanding of the roles of values in the policy decision-making about health-system financing in Latin American countries. The theoretical framework presented in chapter 2 identifies four categories of social and political values (i.e., goals-related values, technical values, governance values, and situational values) playing different roles in government agenda setting, policy development, and policy implementation. The framework also identifies four conditions under which values influence the policy decision-making about health system financing in Latin American countries (i.e., when aligned with policy legacies, with the stronger interest group, with values of the government, and with international influences). The theoretical framework can be thought of as a heuristic that could be used by policymakers to identify and understand how values have been and are being used in the process of agenda setting, policy development, and implementation, in light of the changing historical/political conditions in Latin America. Additionally, policymakers could use the framework to focus their policies according to their objectives (i.e., to achieve important goals, improve efficiency, gain legitimacy, or respond to external influences). On the other hand, stakeholders interested in influencing policy agendas could use this framework to identify which values support or compete with the issues they want to prioritize and the policies they think should be used to address them and/or how to make them more technically sound or socially supported. Moreover, the use of the theoretical framework was explored in chapter 3 using data from documents and media, and in chapter 4 using interviews.

Overall, the findings from the three studies, particularly the framework that emerged from the CIS, contribute to fill an important gap in the available knowledge about

how the goals of health systems are pursued in Latin American countries where private insurance companies are actively seeking to maximize profits.

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Chapter 2. Preface

This chapter takes a broad approach to examining the roles of values in the policy decision-making about health system financing in Latin American countries through the application of a critical interpretive synthesis methodology. Insights gained from the critical interpretive synthesis led to the development of a theoretical framework, which identifies how values inform the agenda setting, policy development and implementation phases of health system financing decisions.

I was responsible for conceptualizing the area of focus of the study, designing the study and executing the data collection and analysis. The included studies were identified from a search strategy executed on December 2016, and the analysis and development of the framework was completed between March 2017 to October 2017. Ivan Florez assisted with assessing documents for eligibility and inclusion in the review. My supervisor (Dr. Michael G. Wilson) contributed to analysis, synthesis and development of the theoretical framework, which was an iterative process. I drafted the thesis chapter and committee members (Dr. John N. Lavis and Dr. Julia Abelson) provided feedback on various drafts, which were incorporated into the final version of the chapter.

Aspect	Study 1 (chapter 2)	Study 2 (chapter 3)	Study 3 (chapter 4)
Questions addressed	4) What values inform decisions about health system financing? 5) How do values inform these decisions? 6) Under what conditions values are influential?	4) What socially and politically declared values are important in making decisions about health-system financing? 5) How do values inform these decisions? 6) Under what conditions were values influential?	4) What declared and undeclared values are important in the decision-making processes about health-system financing? 5) How do values inform these decisions? 6) Why are some values incorporated in these processes?
Design	• Critical interpretive synthesis	– Multiple case embedded-design – Discourse analysis	– Multiple case embedded-design – In-depth semi-structured interviews
Scope	• Health-system financing in Latin America	• Two health-system financing policy decisions in each of Chile and Colombia	• Two health-system financing policy decisions in each of Chile and Colombia
Data source(s)	• Scholarly literature	• Policy documents and media	• Views and experiences of policymakers and stakeholders
Type of values studied	• Declared values	• Declared values	• Declared and undeclared values
Connections between studies	• Developed a framework used as an analytical tool in studies 2 and 3	• Analyzed data using the framework developed in study 1 • Identified and explained the role of declared values to inform analysis in study 3	• Analyzed data using the framework developed in study 1 • Complemented findings from study 2 about declared values with findings about undeclared values • Identified reasons for why declared values identified in study 2 were used
Substantive contributions	• Provides a new theoretical framework of how and under what conditions values influence the policy process on for	• Provides the first analysis of how declared values have informed two health-system financing decisions in each of Chile and Colombia	• Enriches the discourse analysis presented in study 2 to provide first-hand insights from policymakers and stakeholders about which declared and undeclared values were prioritized in the policy

	health system-financing decisions in Latin America		decisions and how and why they were used
Methodological contributions	• Presents an approach for the development of a theoretical framework through a critical interpretive synthesis in a nascent area of study, where the available literature is sparse and methodologically diverse	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, and provides explanation of what values influenced those decisions, as well as how they were influential •	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, enriches the findings of study 2 by identifying undeclared values and interpretations of how values influence the four decisions, and provides the opportunity to explore why some values are incorporated in these policy processes
Theoretical contributions	• Identifies four categories of social and political values playing different roles in the policy development process about health system financing in Latin America, and four conditions under which values influence decision-making in this area	• Identifies what declared values influenced two policy decisions about health-system financing in Chile and Colombia and how those values played a role • Proposes that values entrenched through large structural reforms are central to shaping the many incremental changes made to health systems in subsequent years or decades	• Provides explanations of how and why some values influenced the four decisions, and proposes that policymakers only consider a small set of prioritized and often competing values to simplify the complex interplay of values influencing a particular decision

Identifying values in the health policy decision-making processes about health-system financing in Latin America: A critical interpretive synthesis

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Abstract

Introduction: Every health system in the world embodies values that guide political decisions. Although values underpin the goals pursued in health systems, including how health systems benefit the population, it is often not clear how values are incorporated into policy decision-making about health systems. The challenge is to encompass social/citizen values, health system goals, and financial realities and incorporate them into the policy-

making process. This is a challenge for all health systems, but for low- and middle-income countries (LMICs), which face resource constraints, it is particularly important to decide on those values that should guide how to get cost-effective treatments to those who need them, and to achieve better health status in their populations. Our objective was to understand how and under what conditions societal values inform decisions about health system financing in Latin American countries.

Methods: A critical interpretive synthesis approach was utilized for this work. I searched 17 databases in December 2016 to identify all empirical and non-empirical articles written in English, Spanish or Portuguese that focus on values that inform the policy process for health-system financing in Latin America countries at macro and meso levels. Two reviewers independently screened records and assessed for inclusion. One researcher conceptually mapped included articles, created structured summaries of key findings from each using frameworks related to government agendas, policy development, and implementation; and selected a purposive sample of articles to include in the synthesis. I thematically synthesized the results across the domains of agenda setting/prioritization, policy development, and implementation.

Results: Our searches identified 5925 unique references, from which I included 199 papers and synthesized 77 papers. Articles were focused on health systems of countries in Central America (n=36), South America (n=81), Central and South America (n=13) or with a general scope in Latin America (n=69). I identified 116 values in the 199 papers included; I found from this that stakeholders and policymakers in Latin American call a great variety of things "values." I developed a framework to explain how values have been used to inform policy decisions about health system financing in Latin America. This framework

has four categories: 1) goal-related values (i.e. guiding principles that pursue the best health for all, and according to their needs); 2) technical values (those incorporated into the instruments and strategies adopted by decision makers to ensure a sustainable and efficient health system); 3) governance values (those applied in the policy process to ensure a transparent and accountable process of decision-making); and 4) situational values (a broad category of values that represent competing strategies to make decisions within health systems). I identified four conditions under which situational values come to be influential in the policy decision-making about health system financing in LA: 1) when aligned with international influences; 2) when aligned with policy legacies, 3) when aligned with values of the government; and 4) when aligned with the stronger interest group. **Discussion**: The review and framework that emerged from this analysis represent an effort to consolidate and explain how different social values are considered and how they support policy decision-making about health system financing in Latin America. This theoretical development can help policymakers to explicitly incorporate values into the health policy process and understand how those values are supporting the achievement of policy goals in health system financing.

Introduction

Every health system in the world embodies values that guide health policy decisions.(1–3) These values are essential at all stages of the policy process, ranging from the prioritization of some issues over others on a government's agenda to the development of policy options to address an issue and the implementation of selected policy options. When governments or institutions more generally set agendas and develop and implement policies, they also legitimize and promote certain values over others, making decisions about health systems value-laden.(4)

Although values underpin the goals pursued in health systems and often the means for achieving them, including how health systems and particular health policies benefit the population, it is often not clear how values are incorporated into policy decision-making about health systems. This is perhaps not surprising given the complexity of decision-making about health systems, the wide range of values prioritized (and advocated for) by different stakeholders, the broad array of sources for or mechanisms available to identify values, and the many ways in which values can drive policy decisions, as well as the reality that policymakers often do not want to be explicit about the values used in policy decision-making process.(5) Yet clarity may be all the more necessary in the resource-constrained health systems of low- and middle-income countries (LMICs), where the values guiding how to get cost-effective treatments to those who need them, and to achieve better health status in their populations, can have particular direct impacts.(1)

In Latin America specifically, the identification of values used in the policy decision-making process is an emerging field, and there is a paucity of evidence about the role of values and how they inform the prioritization, development, and implementation of

policies in different contexts. Latin America has a vibrant history of political fluctuations: in the last 30 years, political contexts have spanned the spectrum from authoritarian governments to democracies led by right-, center- or left-aligned governments. However, there is little evidence about how such changes in context influence the values chosen to guide policy decision-making about both health systems financing and arrangements. Indeed, in our preliminary search for this synthesis, to the best of our knowledge no systematic review has specifically focused on values in Latin American health systems.

Given the paucity of synthesized evidence, I focused on understanding how and under what conditions societal values inform decisions about health system financing. I focus on health system financing decisions since they typically need to balance more visibly competing values than decisions about governance or delivery arrangements given the different role of public and private finance and the different values driving those approaches to financing systems. Insights in this area could help policymakers and stakeholders to know how values are being incorporated into the policy decision-making process in health-system financing, and potentially make changes to better support the more explicit use of values in policymaking about Latin American health systems.

Methodology

I used a critical interpretive synthesis (CIS) for this review given its appropriateness to answer research questions that need to draw on a heterogeneous body of literature that is not particularly well developed or focused,(6,7) which is the case with the literature related to the use of values to inform the policy decision-making process about health-system financing in Latin American countries.(8) The CIS approach is based on analyzing

perceptions and interpretations drawn from a wide-range of relevant sources to develop a framework that explains the phenomenon being studied. Moreover, the CIS approach is not based on a pre-specified design or quality of documents but rather on the relevance of papers to the theory.(7)

For our CIS design, I used an explicit and structured search of the indexed literature followed by a more inductive purposive selection of papers from the pool of relevant documents to include in the analysis. I also adopted an iterative approach to refining the research question to carrying out additional searches to fill conceptual gaps that emerged during the analysis.(9)

As proposed by Dixon-Woods et al., I adopted a "compass" question to underpin the design and conduct the review,(6) which was "how and under what conditions do Latin American countries use values to make decisions about health-system financing?" As the compass question suggests, the primary purpose of the synthesis was to explain how factors may influence the way in which policymakers in Latin America use values to make decisions about financing in their health systems, and under what conditions values come to be influential in the policy-making process.

Literature Search

In December 2016, I searched 17 databases to identify relevant literature (Applied Social Sciences Index and Abstracts, CINAHL, Embase, Healthstar, Health Systems Evidence, International Political Science Abstracts, LEYES, LILACS, MEDLINE, PAIS International, ProQuest Political Science, PsycINFO, SciELO, Social Science Abstracts, Sociological Abstracts, Web of Science Core Collection from Thomson Reuters, and

Worldwide Political Science Abstracts). Collectively, these databases index literature from a diverse range of subject domains, which allowed us to identify articles addressing a broad spectrum of situations in which values inform decision-making about health system financing.

The search strategy was comprised of both controlled vocabulary, such as the National Library of Medicines MeSH (Medical Subject Headings), and keywords. In general, our search combined terms related to the region of interest (e.g., Latin America, South America, Central America, and any of the countries in the region, individually) with contextual or intervention terms related to the topic area (i.e., health-system financing and financial arrangements) and with terms related to the main area of interest (i.e., values). In addition, I searched websites of the World Health Organization, Pan American Health Organization, and World Bank to identify additional published and unpublished literature. Lastly, I conducted purposive searches to identify literature to fill conceptual gaps that emerged during our inductive process of synthesis and analysis (e.g., to understand how policymakers address values like right to health, equity or universality).

The search strategy was developed in consultation with a library scientist at the University of Antioquia and then peer-reviewed using the PRESS checklist before being finalized (see Appendix 1 for the detailed search strategy).

Selection Criteria

I included all empirical and non-empirical articles written in English, Spanish or Portuguese that focus on values that inform the policy process for health-system financing in Latin America countries at the macro (i.e., supranational, national and sub-national) and

meso (i.e., administrative regions, healthcare organizations) levels but not at a micro level (i.e., clinical decision-making by health professionals).

Reference Reviewing & Article Selection

Step 1 - Reviewing

One researcher (CMV) reviewed and assessed the titles and abstracts of all references captured by our search strategy to exclude those references that did not address the topic of interest or a Latin American country. Second, two researchers (CMV and IDF) assessed the titles and abstracts of the remaining references to classify them as "potentially relevant" or "exclude," any disagreement at this stage was addressed by including the reference in the next step. Third, I retrieved the full text of all potentially relevant articles, which were then reviewed independently in duplicate by two researchers (CMV and IDF) to make a final assessment of whether they were relevant to understanding how and under what conditions values inform decision-making about health system financing in Latin America countries (and hence included in the sample frame from which I drew our purposive sample for the synthesis). Any disagreement at this stage was resolved by consensus. A Table of studies excluded at this stage was prepared to document the reasons for exclusion (See Appendix 2 for details of articles excluded.)

Step 2 – Conceptual mapping & purposive sampling

I conceptually mapped the included papers using a structured form. The form included categories for document features and for variables of interest, including:

setting/country, research/non-research, value(s) addressed or discussed; government agenda-setting factors drawn from Kingdon's framework;(10) and policy development and implementation factors drawn from the 3I+E framework (see appendix 3 for details of frameworks).(11)

I then used this mapping exercise to identify areas that were conceptually rich and areas where there appear to be conceptual gaps, which served to guide our selection of a purposive sample of relevant papers. The purposive sample was selected based on the following criteria: 1) articles were conceptually rich, defined as articles that addressed two or more factors included in the conceptual mapping and which describe and discuss policy decisions in depth; 2) articles captured a breadth of perspectives across different Latin American countries; and 3) articles that provided perspectives from different periods of time. The principal investigator (CMV) performed the conceptual mapping, as well as the assessments of which papers are likely to offer important conceptual insights and the countries of focus, to select a conceptually rich set of papers to include in the analysis.

Data extraction

In addition to categorizing included articles, I extracted relevant data from them by developing a summary of key findings and conclusions related to our compass question. These summaries were developed by one researcher (CMV) and checked by another (IDF). A log book has been kept by CMV consisting of organized memos that document emerging themes used in the synthesis of findings phase.

Briefly, the data extraction for each paper consisted of: 1) identifying all values addressed; 2) describing the meanings and definitions of each value (when available); 3)

identifying the explicit or implicit mechanism of use for each value; 4) determining the stage of the policy process in which values were used; 5) connecting the mechanism of use of each value to each component of the Kingdon's framework and the 3I+E framework; 6) identifying social, economical, or political factors that explicitly or implicitly were influential for prioritizing the value; and 7) identifying which actors (e.g., academia, doctors' organizations, international agencies, international donors, patients, pharmaceutical companies, policymakers, researchers) support or oppose the value.

Synthesizing findings

To allow for an interpretive synthesis, I used qualitative methods to analyze and synthesize data from a purposively selected set of included studies. Our selection of the final sample was based on papers that: 1) focus or explain policy decision-making about health system financing in one or more countries in Latin America, 2) capture a breadth of perspectives across the same country or different countries about how and under what conditions values are used in decision-making about health system financing; and 3) describe the agenda-setting, development or implementation of policies where the role of values was identified. Although this synthesis included an element of aggregation (i.e., identifying those findings that recurred most frequently across included studies), the primary function of this synthesis was interpretation. To do this, I used a constant comparative method throughout the analysis to develop an explanatory framework of how and under what conditions Latin American countries use values to make decisions about health-system financing, which allowed us to ensure our framework is grounded in the data from the included papers. For the analysis, factors that influence or explain how values are

used and under what conditions values inform the policy decision-making about health system financing were used as independent (explanatory) variables and the use of the value in the policy process as the dependent variable. Finally, exclusive categories of values were proposed, and all values identified in the papers were assigned to one of the categories proposed. Values that might fit in more than one category were assigned to only one considering the similarity with other values within the category. The mechanisms identified through the analysis were assigned both to a category of values and each stage of the policy process.

Results

The electronic database search yielded 6481 published articles. After removing duplicates, 5925 articles remained for screening, from these I excluded 5528 records due to lack of relevance and duplicates. Of the 397 full-text articles screened, 199 met the inclusion criteria; eight papers were purposively identified to fulfill gaps of our theoretical framework, for a total of 207 papers that were conceptually mapped (see appendix 4 for details of all conceptually mapped articles, including whether they were later purposive sampled after full-text review).

Of the 207 included articles, 141 were written in English, 46 in Spanish and 19 in Portuguese. Articles were focused on health systems of countries in South America (n=84), Central America (n=36), Central and South America (n=14) or with a general scope in Latin America (n=73) (Figure 1). Brazil was the country most commonly addressed (22%; n=45), followed by Mexico (14%; n=28), Chile (11%; n=22), Colombia (10%; n=20) and Costa Rica (5%; n=10) (see Figure 2 for number of times each country was specifically

addressed). From the 79 articles that reported on findings from primary research, 12 were systematic reviews, 49 were quantitative studies, 26 were qualitative studies, and four used mixed method.(12–16) The most common types of papers among the non-research articles were discussion papers (38%; n=49) and situation analysis (23%; n=30) (see Table 1 for general characteristics of included and purposive sampled papers). From this list of 207 included articles, I selected 77 papers to include in our purposive sample for data synthesis (see Figure 3, PRISMA Chart).

I identified 116 values in the 207 papers included (see Appendix 5 for the list and frequency of values identified). I found from this that stakeholders and policymakers in Latin American call a great variety of things "values" in their writings, including: the right to health, equity, universality, sustainability, decentralization, feasibility, privatization, primary healthcare, Millennium Development Goals, and many more. Further, these values describe concepts that are quite different from each other, such as principles, strategies, instruments, specific goals, elements of a policy, or beliefs about the health system. The top fifteen values (unaltered and ungrouped) more frequently identified in the papers reviewed were: equity (46%; n=95), universality (36%; n=74), efficiency (35%; n=72), accessibility (31%; n=61), decentralization (23%; n=46), quality (19%; n=38), financial protection (18%; n=30), right to health (14%; n=29), sustainability (14%; n=28), solidarity (13%; n=27), social participation (13%; n=27), privatization (12%; n=25), accountability (12%; n=24), effectiveness (12%; n=24), and market (10%; n=21).

Development of a framework

I developed a framework to explain how values have been used to inform policy decisions about health system financing in Latin America (see Table 2 for a general explanation of the categories and how they influence the policy process). The tension in developing such a framework is that values can be used as ends or means.(5) Therefore, values can be articulated as desirable outcomes to be achieved in the long term, or used as concrete strategies or actions to achieve these desirable goals. Considering this, I have organized a framework according to four categories of values (see Figure 4 for a graphical representation of the framework): 1) goal-related values (i.e. guiding principles that pursue the best health care for all, and according to their needs – namely universality, equity, quality and solidarity); 2) technical values (i.e. those incorporated into the instruments and strategies adopted by decision makers to ensure a sustainable and efficient health system); 3) governance values (i.e. those applied in the policy process to ensure a transparent and accountable process of decision-making); 4) situational values (i.e. a broad category of values that represent competing strategies to make decisions in the health systems). I also identified four conditions under which situational values come to be influential in policy decision-making about health system financing in Latin America: a) when aligned with policy legacies; b) when aligned with the interests of influential groups, c) when aligned with the ideology of the government; and d) when aligned with international influences.

How values are used

In describing these values, I provide interpretation (based on the literature identified from our searches) about how each is used to understand better their role in informing policy decisions (see Table 2 for details of how categories of values are influential).

Goal -related values

I developed this category with those values more commonly identified as guiding principles of health systems in the papers reviewed.(17–21) I made a distinction in this category between the core and intermediate values to be able to highlight that the core values of equity, quality, solidarity, and universality, are those that best represent societal expectations for the health system. Also, these core values each contribute to the broader principle of the right to health, which is an important and ongoing matter of debate in Latin America (e.g., the increase of 'tutelas' in Colombia).(17,22–24)

Despite core values being very important in health systems and commonly considered, they have different meanings or connotations depending on the perspective of each government. For example, universality is a value of almost every health system in Latin America,(25) and a principle promoted by the World Health Organization (WHO).(3,26,27) However, while universality has been prioritized as a key goal, there is no consensus on its meaning and scope,(25,28–31) and therefore is not possible to design a common indicator to measure it, or even agree on the extent to which it can be achieved.(25)

The lack of consensus on the conceptual definitions of universal health coverage has resulted in different interpretations depending on the disciplinary perspectives and philosophical views and contexts.(28–30) Considering those different perspectives, universality can be understood from three approaches: traditional universalism, basic universalism, and residual universalism.(28) Each of these perspectives implies a different mechanism to frame the problem (e.g. different indicators), as well as different forms of

developing and implementing policies that fit with the point of view of the approach (See Table 3 for an explanation of how a goal's perspective plays a role in the policy process).

Moving to intermediate values, I propose that they are necessary factors to achieve goals. The role that intermediate values play in policy decision-making about health system financing varies based on the context of each country, because they represent intermediate steps to achieving the goals of the health system. For example, Colombia and Costa Rica have declared universality as a guiding value of their health systems, but according to the perspective of each government, they have prioritized different intermediate values: availability in Colombia and accessibility in Costa Rica.(19)

Intermediate values not only serve to achieve one core value, but they could also have intricate interrelationships to both, thereby helping to achieve more than one of the core values and to strengthen other intermediate values. For example, acceptability is not only an intermediate value to achieve universality, equity, and quality; it is also a value that strengthens accessibility, availability and affordability.

Technical values

Given that the right to health has deep and wide connotations, and the procedures, technologies, services, and programs that come to satisfy it are increasing in number and costs day by day, governments must define reasonable limits to ensure the achievement of goals. Those limits and the instruments to ensure that goals-related values are successfully reached should be defined by technical and rational rules that assure the efficiency of the resource allocation. In this point, technical values like austerity, effectiveness, evidence-based, feasibility, planning, prioritization, rationality, or sustainability, are essential

elements to the extent that they help to organize the health system to be durable over time. Sustainability is not by itself a final goal of the health system, but a means for attaining health for all according to their needs.

Governance values

The seriousness of the health policy decision-making requires that the procedures for making decisions reflect values like accountability, social participation, stewardship, and transparency. Governance values are not final goals of the health system but promote the principle of legitimacy in health policy development and implementation. For example, accountability and transparency have progressively begun to appear as essential values in Latin America,(21,32–35) and they have been emphasized as imperative goals for addressing corruption.(36,37) Governance values do not, on their own, achieve other goals or the materialization of the right to health, but their presence in the policy decision-making process allows to the citizens to ensure that core values are considered in each policy decision.

Situational values

Situational values are values that become important in specific circumstances. These values reflect policy legacies, changes in the balance of organized forces, interests of influential groups, ideological positions, changes in the national mood, or international influences. I propose that situational values are not the ultimate goals of the health system. However, some situational values become tremendously important for a country at particular points in time, and governments could incorporate them to the technical or

governance categories, or even misrepresent their role and feverously pursue them as though they were a goal of the health system.

For example, at the end of the 80´s and 90´s, virtually all countries in Latin America began the process of reforming their health systems and pursued values promoted by the World Bank and the Inter-American Development Bank like "privatization," "competitiveness" and "market". (21,29,30,32,38–40) Reformers maintained that privatization will improve other high standard values like accessibility, efficiency, equity, quality, and social participation.(36,41–45) They delegitimized other approaches to organize the health system arguing that were ideological, not technical, besides they were not sustainable either feasible for Latin Americans.(42,43,46)

This situational values category is complicated because different competing values belong here, and there is no consensus about the legitimacy of those values. For example, some governments highlight decentralization, and others pursue centralization; some countries promulgate compulsoriness, and others ask for voluntariness; some endorse public financing, others prefer privatization. Countries that implemented private health insurance models commonly asserted competitiveness, privatization, market, targeting, cost-containment, and efficiency as the most appropriate mechanisms to achieve universality in a liberal, market-oriented society.(17,21,29,32,39,47,48) Those values are identified in the health system reforms of Brazil,(17,37,49,50) Chile,(29,50) Colombia,(17,37,50,51) Costa Rica,(42) and Mexico.(32,39,52,53) However, when I examined the strategies followed by more public-financing-oriented governments, other values like public financing, primary healthcare, and centralization appear (e.g., Bolivia, Cuba, Ecuador, Venezuela).(41,54–57)

The conditions under which values are used

Each category of values was analyzed according to three stages of the policy process (i.e., agenda setting, policy development and implementation), by considering the factors included in Kingdon´s agenda-setting framework and the 3I framework described in the methods section (see Table 3 for details of the conditions in which values are used in different stages of the policy process).

Agenda setting

Values are used to frame problems in health systems and to prioritize issues on government agendas, they also shape how some issues gain prominence in the government agenda given that this is a precursor for identifying policy options.

When governments compare their indicators based on the goals they hope to achieve with similar indicators or expectations from other countries, such comparisons are important factors in framing an issue as one that warrants a government's attention when those comparisonsresult in negatively framed goal-related values (e.g., lack of universality/solidarity, inequity, bad quality, or vulnerability to the right to health).(19,21,32,34,36,58–60) Governments also pay attention to problems that are framed in relation to inefficiency or as threats to the fiscal sustainability of health systems,(18–22,32,33,61), and more recently to problems regarding corruption, lack of social participation or deficiencies in accountability.

Problems in health systems might also be defined in such a way that feedback from situational influences positions a specific strategy or value on the government agenda.

Situational factors such as the promulgation of international policies (e.g., MDG), or the neoliberal reforms in the 80s and 90s might influence how policymakers define problems to be consistent with the discourse of international agencies. For example, in the 80s and 90s, problems of inequity and lack of universality were framed in terms of out-of-pocket expenditure and financial risk for low-income families. In this context, the value of 'targeting' came to be present in multiple policies.(50,51,62) The objective of targeting in health was to ensure a basic minimum of health services to the poorest population,(43) promoting a subsidy allocation strategy which gave preference to poor families, through capital accumulation or through income-guided selection.(17,32,51) The value of targeting along with financial protection become important in the discourse for the achievement of universality and social justice.(32)

Policy development

Policy alternatives that are aligned with the goals and perspectives of policymakers are more likely to be considered and chosen. For example, a government addressing equity from a utilitarian perspective might be more interested in policies focused on providing financial protection to citizens than in policies focused on achieving gender equity.(20,28,36,38,43,50,53,63)

Technical values play an important role in the policy development given that they are used as pragmatic instruments to develop and select policies that might be feasible and guarantee the sustainability of the health system. For example, effectiveness and cost-effectiveness have been significant values to make decisions about benefits plans, coverage of drugs or technologies, and development of clinical guidelines.(30,64,65)

Governance values come to play a role because they are related to how elected officials and civil servants pay attention to societal groups' demands for transparency and stewardship of the policy process. Policymakers incorporate these values because they think it is the right way to make the decision-making process more efficient, or because donors explicitly demand them.(66) I found that governance values are regularly used at the end of the policy development as a strategy to improve the social acceptability of the policy chosen. For example, many stakeholders critique that social participation is only considered after the policies have been completely developed (e.g., for the purposes of informing or notifying)(42–44) They further argue that governments are looking for social participation to reinforce the symbolic identification of health with democracy, not because they think that social participation would improve the health system performance.(44)

Situational values come to be influential when the policy option is aligned to: a) influential policy legacies (e.g., the financing structure of the health system, public vs private); b) interests of influential groups; c) the ideology of the government (e.g., left vs. right); or d) international recommendations or requirements.

As in others domains of the socio-political life in Latin America, values underlying the orientations of the current governing party (e.g., left vs. right) are reflected in the policy decision-making about health system financing (See Table 3 for details of what values and examples of which countries).(42,67) For example, when Brazil and Chile are followed over time, it is possible to identify values that represent the neoliberal ideology during the dictatorships and right-wing governments,(37) but when those countries moved towards social-democratic governments, the prevailing values were right to health, equity, prevention, and interculturality.(37,68) Mexico and Colombia further highlight this

finding. These countries both have capital cities that have a significant level of independence from the national government (Mexico DF -Federal District- and Bogota DC -Capital District-). In those countries, provincial governments of center-left diverged in their values about the health system in comparison to the national right-wing governments. In Mexico, the implementation of social medicine in Mexico DF (2000-2006) gave great importance to strengthening public institutions and eliminating barriers related to individual payment capacity and market rules,(62) which were contrary to the values of the national right-wing government. In the same way, the left-aligned government of Bogota in 2011, considered a set of values (i.e. the right to health, prevention, primary healthcare, and equity) to plan its health policy in a way that differed to the pro-market values of the right-wing national government.(69)

Policies aligned with the values of international agencies/donors, their recommendations or requirements, are more likely to be chosen.(47,70,71) Several included papers highlight the role that the World Bank (WB) and the International Monetary Fund (IMF) had in health systems reforms in Latin America and other low-and-middle-income countries in the world. For example, the set of values promoted by these agencies in the 80's and 90's were adopted by the Latin American countries by the diffusion of ideas or by coercion to access to loans.(36,43) Other agencies such as the World Health Organization (WHO), the Pan-American Health Organization (PAHO) and United Nations (UN) have also influenced the set of values that are considered in decisions about health system financing. One of the mechanisms of influence is by national governments framing their health problems based on reports issued by these agencies,(36,58) and introducing and prioritizing new values into the policy process based

on these framings. The other mechanism is adopting strategies recommended by these international agencies to achieve those values.(72,73)

Despite the strong influence of international agencies over decision-making in Latin America, policy legacies are also important in the policy process, and the values aligned with those legacies (e.g., the financing structure of the health system, public vs. private) come to be influential. For example, while the World Bank promoted residual universalism, each Latin American country implemented policies to address universality in ways that were most aligned with the priorities of the governing party, policy legacies and the national mood. As a result, while universality was highlighted as a core value in Latin American countries, the ways in which it has been operationalized through intermediate values have differed based on specific political and health system features of each country. Therefore, it is possible to identify a mix of traditional forms of universalism for workers and their dependents, and minimal universalism for the unemployed, indigenous and vulnerable populations (e.g., Colombia).(29,38,52,55)

Policies aligned with interests or the values of organized groups (doctors, patients, private sector) can also be influential. In some cases, influence can emerge from interest groups having strong connections to the government (e.g., pharmaceutical companies), and in others, it can be driven by public opinion that is aligned with the interests of a group of patients, organizations/coalitions of doctors. Alternatively, influence can be driven by interest groups that are positioned in a way that can help to achieve other goals like accountability or help to assure the effectiveness of medical interventions. For example, the value of being evidence-based has been promoted by organizations of doctors and

researchers, and it is an important technical value to assure that health systems deliver cost-effective interventions and that decisions are made rationally.

Policy implementation

Core goals-related values are the most common factors to evaluate the global performance of health systems, even for policies that do not explicitly pursue the achievement of those goals. Intermediate values are also considered as desirable and measurable surrogate outcomes of the health system and might be preferred by policymakers because they are more attainable. (14,53,74–77)

Governments also consider technical values in the phase of policy implementation, because values like efficacy, financial protection or sustainability can help them to achieve a better performance of the health system, and help to gain accountability, transparency, and trust in decision-making. Recently, as a consequence of the diffusion of ideas and successful experiences, values such as evidence-based, and cost-effectiveness, have come to gain importance, and governments have begun to incorporate them into decision-making process routinely. The incorporation of new technical values, free of international pressures, is a phenomenon consistent with the development of technical capacities within the countries, and the economic growth of Latin America.

Governance values have been used as indicators of how authority in the health system is exercised. Those values are used to monitor the performance of the government and the engagement of the citizens and interest groups into the policy process. Values such as accountability and transparency have progressively begun to appear as essential values

for policy implementation,(21,32–35) and are emphasized as imperative goals against corruption.(36,37)

Situational values are not only used to prioritize policies to be implemented when aligned with specific situational influences, but also for: the evaluation of the success implementation of particular initiatives of a government; the adoption of foreign policies (policy transfer); extent the power of some interest groups; and measure the level of progress in the implementation of a specific model of health system financing. For example, decentralization was a value frequently identified in the papers reviewed, and in fact, in the 80's and 90's many governments considered decentralization as a goal of health systems.(36,50,67) As a result, countries sought some form of transfer of responsibilities from the center to the periphery of health systems,(38) as well as the process of municipalization (or districts), transfer of services to jurisdictions, or the delegation of management autonomy to hospitals.(50) Although decentralization implied different strategies that differed in scope, in the number of functions transferred, levels of government involved, and the participation or not of private organizations (i.e., deconcentration, delegation, devolution, and privatization);(67) this strategy was prioritized to be implemented for virtually all the countries in the region.

Discussion

Principal findings

This review and the framework that emerged from the analysis, are an effort to consolidate and explain how and under what conditions different social values are taken into consideration and support the policy decision-making about health system financing

in Latin America. I propose that the values considered in the policy process can be characterized in four ways: 1) goal-related values (i.e. guiding principles of the health system); 2) technical values (those incorporated into the instruments adopted by policymakers to ensure a sustainable and efficient health system); 3) governance values (those applied in the policy process to ensure a transparent and accountable process of decision-making); 4) situational values (a broad category of values that represent competing strategies to make decisions in the health systems). This theoretical framework is represented in Figure 3, which can be thought of as a heuristic that can be used to identify the four categories of values and the conditions in which values are used in different stages of the policy process.

These categories of values come to be influential in government agenda setting by framing the problems in specific ways, by prioritizing some health issues in the government agenda, or by giving legitimacy to the process of agenda setting.(10) In policy development, values are used as pragmatic instruments to inform policy development, influence what policy options are more likely to be chosen, and to improve the acceptability of the policy options that are selected.(11) In policy implementation, values influence which policies are more likely of being prioritized for implementation, are used as indicators for evaluating the general performance of the health system and are used as indicators of good governance and as strategies against corruption.

I identified four conditions under which values influence policy decision-making about health system financing, which include: a) when aligned with policy legacies (e.g., the financing structure of the health system, public vs private); b) when aligned with interests of influential groups; c) when the policy option is aligned with the ideology of the

government (e.g., left vs. right); and d) when aligned with international recommendations or requirements.

Findings in relation to other studies

In relation to the broader literature, I share two findings with the study of Giacomini et al. about values in the Canadian health system, and I build on sets of values that have been outlined by international agencies. The first similar finding to Giacomini et al. is that stakeholders and policymakers use 'values' to refer to many things, such as different principles, strategies, instruments, specific goals, elements of a policy, or beliefs about the health system. The second finding aligned with Giacomini et al. is that the contradictions about values are not between people for or against equity, but between people who prioritize equity and those who prioritize sustainability, or between people promoting policies addressing equity from an egalitarian approach and those who promote policies developed from a utilitarian or Rawlsian perspective.(5)

In relation to core sets of values that have been previously articulated, our searches did not identify previous studies that developed a framework explaining the role of values in the policy decision making in Latin America, although the World Health Organization and the International Covenant on Economic, Social and Cultural Rights (ICESCR), have promoted the idea of a core set of values. These organizations prioritize values that guarantee "the enjoyment of the highest attainable standard of physical and mental health."(78) The values ('essential elements') promoted by the WHO and ICESCR are availability, accessibility, acceptability, quality, and the delivery of healthcare free of any discrimination. Our framework shares the core value of quality, but I propose that

availability, as well as accessibility and acceptability are components or intermediate steps to achieve the four most significant values needed to achieve the right to health. For example, if a health service is available but only for people living in urban areas, or only for those who can afford it, then that health service is not aligned with the values of universality and equity. Also, if a diagnostic test is accessible only for people who can pay, even if they do not need that test, at that point I cannot say that this service is delivered according to values of equity, solidarity, universality, and quality.

Strengths and limitations of the study

There were three strengths and two potential limitations of this critical interpretive synthesis that are worth noting. The first strength is that the CIS was an appropriate methodological approach to synthesize heterogeneous sources of literature, empirical and conceptual papers considering or displaying debates about values in Latin American health systems, and articles discussing policies in health system financing. Second, the structured and systematic electronic search and the method of purposive sampling allowed us to be rigorous and transparent in the process of answering our compass question. Third, I included papers written in English, Spanish and Portuguese, which are the languages of the Latin American publications, and in doing this, I ensured that I covered all the possible documents with relevant values about health system financing in Latin American countries.

One potential limitation of the study was that terms used in the literature were diverse and at times vague. Therefore, the search strategy may not have captured all of the terms and concepts related to this topic. However, I performed a rigorous process of inclusion assessment independently in duplicate by two researchers of the papers identified

in the searches to guarantee that different concepts, approaches, and reflections of values were considered. The second limitation is that I only considered declared values, making possible that important values taken for granted by policymakers and stakeholders that are not explicitly declared might be missed in this analysis and therefore considered as not important or not prioritized. However, this limitation cannot be addressed through synthesis methods, and instead requires complementary study designs that use qualitative methods.

Implications for policy and practice

The results of our study are useful for policymakers and stakeholders in Latin America. Both can use this framework to identify and understand how values have been and are being used in the process of prioritization, policy development, and implementation, in light of the changing historical/political conditions in Latin America. Additionally, policymakers could use the framework to focus their policies according to their objectives (i.e., to achieve important goals, improve efficiency, gain legitimacy, or respond to external influences). On the other hand, stakeholders interested in influencing policy agendas could use this framework to identify which values support or compete with the issues they want prioritized, and the policies they think should be used to address them and/or how to make them more technically sound or socially supported.

Implications for future research

The framework developed in this CIS can be used to analyze data, or compare findings in future studies about the role of values in policy decision-making about health

system financing in Latin American countries, but also in a different priority health policy domain (e.g., delivery arrangements or governance arrangements), in a different jurisdiction (e.g., developed countries, other LMICs), or in a different policy field (e.g., education, child policy, social policy).

Future testing of this theoretical framework through case studies, cross-country comparisons, or other methods that analyze specific financing decisions in Latin American health systems could be beneficial to identify gaps in the framework, additional mechanisms by which values are persuasive, or other conditions under which values influence the policy process. Specifically, it is important to explore, using qualitative approaches, the undeclared values and perceptions of stakeholders and policymakers, to understand if values declared in the official documents are really used in the policy decision-making process about health system financing.

Conclusions

The study of values in the policy decision-making process in Latin America is an emerging field. Our effort to synthesize current information and to develop a framework that explains their role in health system financing is a unique contribution to the body of knowledge in this field, and provides an opportunity to explore the role of values in different types of health policy decisions, different policy sectors besides health, and in other jurisdictions.

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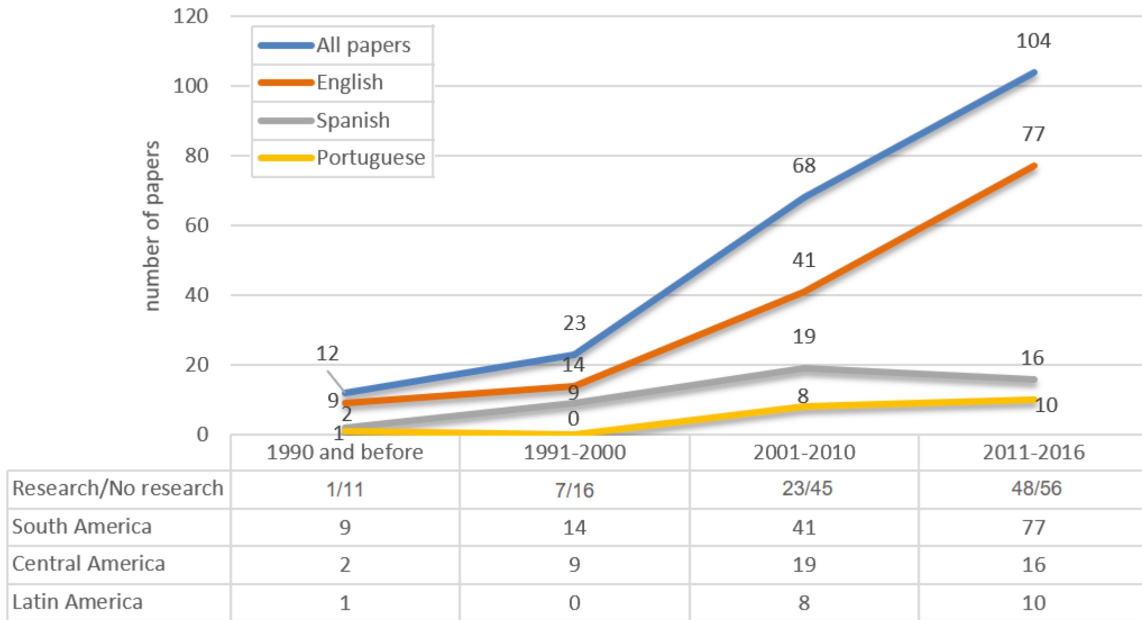
Figure 1. Characteristics of studies included by periods of time



	1990 and before	1991-2000	2001-2010	2011-2016
Research/No research	1/11	7/16	23/45	48/56
South America	9	14	41	77
Central America	2	9	19	16
Latin America	1	0	8	10

Figure 2. Number of times each country was specifically addressed

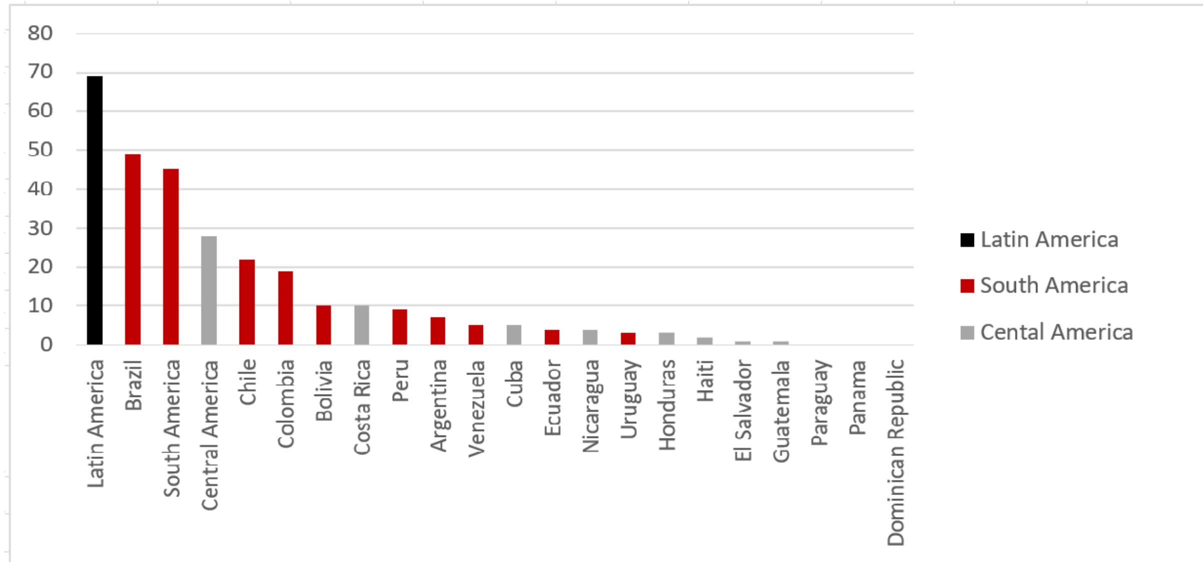
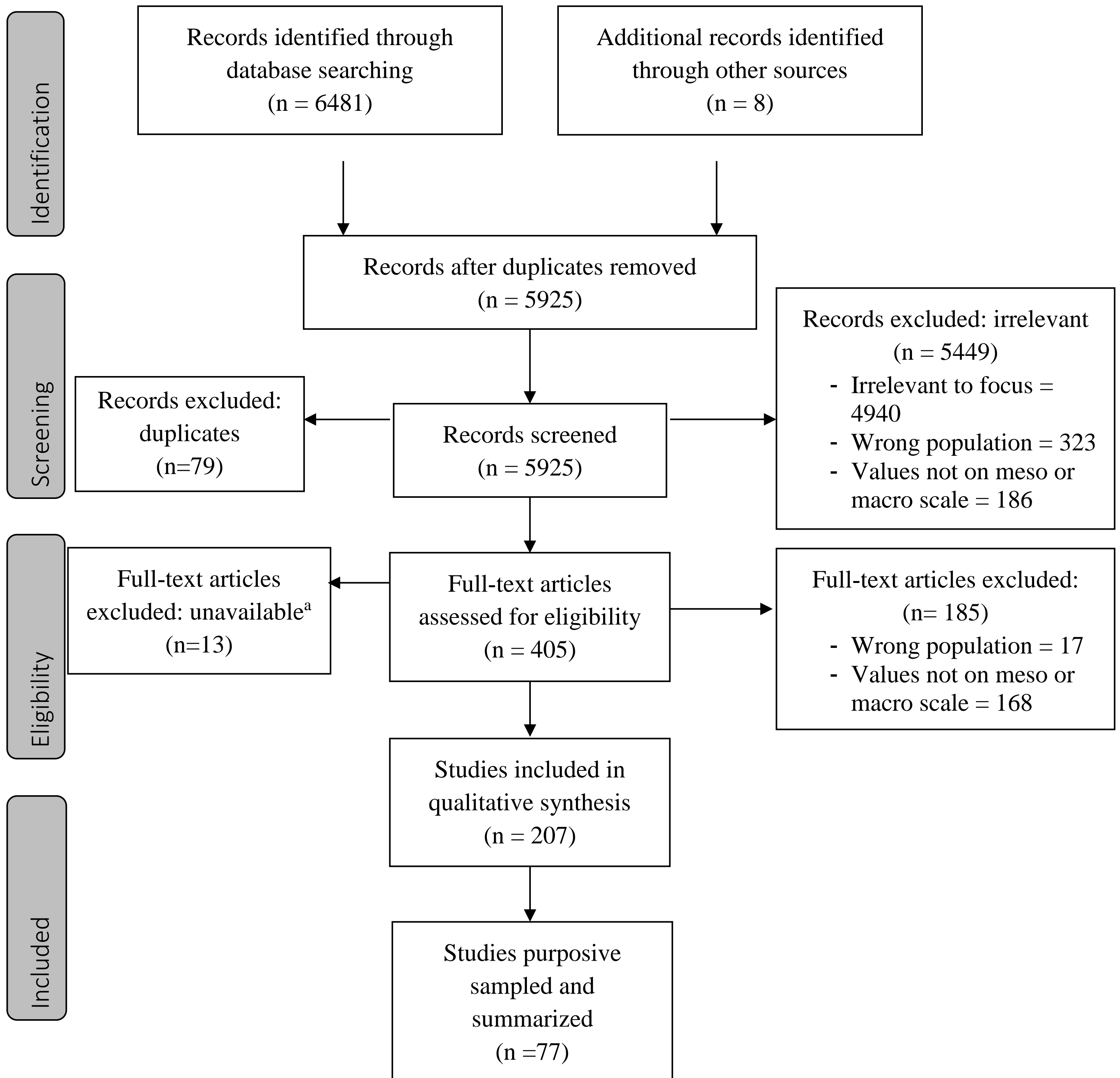


Figure 3. Prisma Chart



[a]After tried both University of Antioquia and McMaster University, as well as inter-library loan

Figure 4. Graphical representation of the framework of values related to health system financing in Latin America

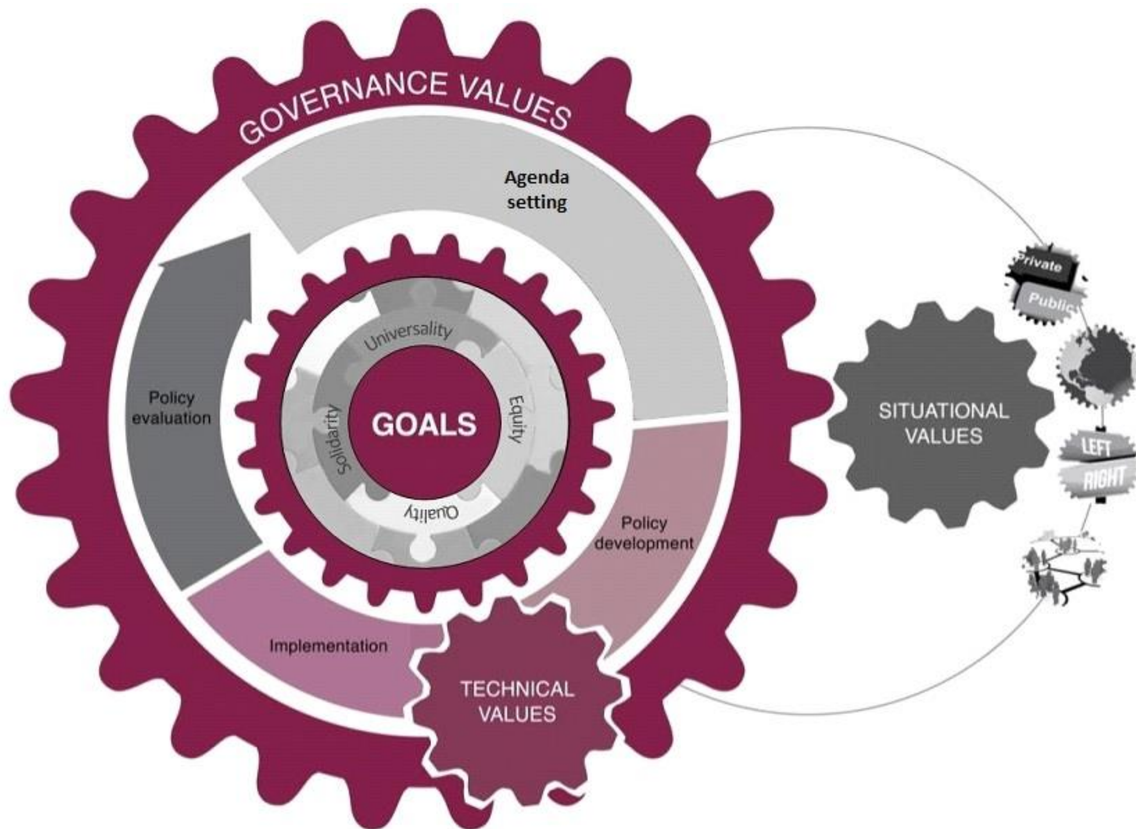


Table 1. Characteristics of all included papers and purposively sampled

		1990 and before		1991-2000		2001-2010		2011-2016	
		All papers included n=12	Purposively sampled n=6	All papers included n=23	Purposively sampled n=8	All papers included n=68	Purposively sampled n=25	All papers included n=104	Purposively sampled n=28
		n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Language	English	9(75)	4(67)	14(60)	6(75)	41(60)	14(56)	77(74)	22(79)
	Spanish	2(17)	1(17)	9(40)	2(25)	19(28)	9(36)	16(15)	5(18)
	Portuguese	1(8)	1(17)	0	0	8(12)	2(8)	10(10)	1(4)
Region	Central America	6(50)	3(50)	6(26)	2(25)	7(11)	5(20)	17(16)	3(11)
	South America	2(17)	1(17)	4(17)	1(12)	26(39)	7(28)	52(50)	15(54)
	Latin America	4(33)	2(33)	13(57)	5(63)	29(43)	10(10)	27(26)	6(21)
	Central & South America	0	0	0	0	6(9)	3(12)	8(8)	4(14)
Primary research	Yes	1(8)	1(17)	7(30)	2(25)	23(34)	5(20)	48(46)	8(29)
	No	11(92)	5(83)	16(70)	6(75)	45(66)	20(80)	56(54)	20(71)
Type of research paper	Quantitative	0	0	4(17)	1(12.5)	14(21)	3(12)	31(30)	4(14)
	Qualitative	1(8)	1(17)	3(13)	1(12.5)	7(10)	1(4)	15(14)	4(14)
	Mixed methods	0	0	0	0	2(3)	1 (4)	2(2)	0
Type of non-research papers	Situation analysis	3(25)	0	6(26)	3(37.5)	11(16)	6(24)	11(11)	5(18)
	Discussion paper	5(42)	4(67)	5(22)	1(12.5)	20(29)	11(44)	19(18)	9(32)
	Other	3(25)	1(17)	5(22)	2(25)	14(21)	3(12)	26(25)	6(21)

Table 2. Categories of values and how they are used

	What are they?	Values identified		How do they work
Goals	• Goal of health systems: the achievement of the best health for all according to their needs • Goals are classified as core values and intermediate values • Core values are: equity, quality, solidarity, and universality • Intermediate values are necessary factors to achieve final goals	**Equity** - Accessibility - Affordability - Afro descendant equity - Availability - Cultural appropriateness - Fairness - Gender equity - Indigeneity - Protection of vulnerable population - Social justice **Solidarity** - Deservedness - Redistribution	**Quality** - Acceptability - Comprehensiveness - Continuity - Cultural appropriateness - Inclusiveness - Integrality - Reasonableness - Safety - Sufficiency - Timely access - User satisfaction **Universality** - Acceptability - Accessibility - Affordability - Availability - Equality - Free access - Gradualty - Progressiveness - Suitability - Utilization	• **Core values are guiding principles of health systems** Each country in Latin America has prioritized some values to guide their health systems over others (39,48) For Costa Rica they were equity, solidarity, and universality; for Mexico, citizenship, fairness and solidarity; for Brazil, equity, participation, and universality; for Chile, equity, participation , and solidarity; and for Colombia solidarity and universality (17–21) • **Intermediate values can be used like midway ends or like means to achieve core values** *For example, when talking about equity, we consider vertical and horizontal equity, as well as accessibility, cultural appropriateness, fairness, and gender equity. All these intermediate values not only serve to accomplish one of the core values, but they could also have intricate interrelationships to both help to achieve more than one of the core values and to strengthen other intermediate values*

	What are they?	Values identified		How do they work
Technical values	Principles that are incorporated into the instruments and strategies adopted by policymakers to ensure that health-system goals are achieved rationally and informed by scientific evidence as well as the economic and social context	**Efficiency-related** - Cost benefit - Cost effectiveness - Cost efficiency - Effectiveness - Efficacy - Efficiency - Financial protection - Sustainability	**Rationale-related** - Austerity - Evidence based - Feasibility - Planning - Prioritization - Professional autonomy - Rationality - Rationing	• **Technical values are related to the instruments to achieve goals** Used as strategies to assure that the health system is able to deliver the best healthcare for all efficiently and sustainably *"The NHS [Cuba] is currently immersed in a thorough analysis of all health care levels with the intent of increasing effectiveness and efficiency, using limited resources to reconfigure services as necessary to achieve better patient-centered and population health outcomes."* (54) *p e18*
Governance values	Values of the political decision-making process that ensure the government considers the concerns of society, and performs its functions in a transparent and accountable manner	**Authority focused** - Accountability - Enforcement of regulation - Governance - Responsiveness - Stewardship	**Public focused** - Public participation - Social participation - Transparency - Trust	• **Governance values are related to the process of political decision-making** Promote that health policies be developed and implemented with social legitimacy (i.e., policies are desirable, proper or appropriate within some socially constructed system of norms, values, and beliefs) *"The concept of health governance refers to the way in which political actors within health system (providers) and the civil society (users, community leaders and NGOs), by means of explicit processes and rules, interact to produce, distribute and consume health as a good in relation to health services demand and population health needs."* (34) *p 39*

	What are they?	Values identified		How do they work
Situational values	A broad category considering different factors that represent interests, ideas or visions of the health system, which vary according to changes in government or the social mood and that can strongly influence policy decision making	**Political system-related** - Hierarchization - Reciprocity - Separation of functions - Sovereignty **Health system structure-related** - Centralization - Compulsoriness - Decentralization - Intersectorality - Pluralism - Unification - Voluntariness **Right to health oriented** - Citizenship - Democratization - Empowerment - Millennium Development Goals - Prevention - Primary healthcare - Public financing - Social cohesion	**Management-related** - Institutional autonomy - Cost containment - Financial autonomy - Financial stability - Optimization - Proportionality - Savings - Self management - Simplicity - Transferability - Transparent procurement **Delivery focused** - Flexibility - Implementability - Mobility - Portability **Market oriented** - Competitiveness - Demand subsidies - Free choice - Individuality - Market - Privatization - Profitability - Self financing - Targeting	• **Situational values come to be influential according to specific situational circumstances** These situational factors depend on policy legacies, changes in the balance of organized forces, changes within the government, or international influences. Some situational values become crucial for a country at a specific time, and governments could incorporate them in the technical or governance categories, or even misrepresent their role and strongly pursue them as though they were a goal of the health system. *Many countries that implemented private health insurance models commonly asserted competitiveness, cost-containment, efficiency, market, privatization, and targeting as the most appropriate mechanisms to achieve universality in a liberal, market-oriented society.* (17,21,29,32,39,47,48) *Those values are identified in the health-system reforms of Brazil,*(17,37,49,50) *Chile,*(29,50), *Colombia,*(17,37,50,51) *Costa Rica,*(42) *and Mexico.*(32,39,52,53) *However, when we examined the strategies followed by more public-financing oriented governments, other values like public financing, primary healthcare, and centralization appear.*

Table 3. The conditions under which values are used in different stages of the policy process

Category & stage		Conditions under which values are used

Goals	Agenda setting	**Problems**
		• **The lack of achievement of goals define the principal challenges faced by health systems**
		  ○ Goals are problematized when recognized negatively (e.g., when framed as low quality, inequity, the lack of solidarity/universality, or vulnerability to the right to health) (19,21,32,34,36,58–60)
		• **The perspective underlying the goals frames the problem in a specific way**
		  ○ Although equity, quality, solidarity, and universality are important, commonly there is not a unique definition for each them.(29,62,79) In the case of equity, it is possible to identify egalitarian, utilitarian and "Rawlsian" approaches to equity. In an egalitarian perspective, health services should be distributed equally for all: in the utilitarian perspective, health services should be distributed based on who gets more out of them; and in a Rawlsian perspective, inequalities in health are allowed if the status of the disadvantaged people is better than in a scenario of complete equality (19,80)

		Policies • **The perspective underlying the goals shape how some issues gain prominence in the government agenda given that this is a precursor for identifying policy options.** ○ For example, there is no consensus on the meaning and scope of universality. (25,28–31) For legal and human right scholars, universality equates to the right to health and implies "equal or same entitlements" to the benefits of a health system.(25) From the perspective of health economists, universality is closely related to financial protection, which leads to a focus on policy options that prioritize prepaid mechanisms such as tax revenue, contributions from social health insurance, and private health insurance in order to minimize out-of-pocket payments and prevent financial bankruptcy. In contrast, from the perspective of public health, universality is considered in relation to defining population-level priorities in health, and the package of effective interventions that is needed to comprehensively address those needs (25)

Category & stage		Conditions under which values are used
		Politics • **The comparison of the goal against what it has achieved is an important factor in agenda setting** o When governments compare their indicators of what the goal has achieved with their national expectations or indicators from other countries, a bad result could be a catalyst for agenda-setting (32,36)
	Policy development and implementation	**Institutions** • **Policies that are aligned with health-system goals are more likely to be prioritized for implementation** o This situation is especially the case when governments have signed on to international commitments such as the MDG (14,75–77)

		Ideas
		
		• **The perspective underlying the goals influence on what policy option is more likely to be chosen**
		  o This determines how policies are developed and which policy options are more likely to pass (20,28,36,38,43,50,52,63)
		• **Policy alternatives that address intermediate goals may be preferred because they are more feasible to achieve**
		  o Given that core values are very broad and imply the satisfaction of multiple dimensions, policies that focus on specific intermediate values might be preferred in policy development (74)
		• **Goals are used as indicators for evaluating the general performance of the health system**
		  o Indicators of equity, quality, solidarity, and universality are the most common ways to evaluate the global performance of health systems, even for policies that do not explicitly pursue the achievement of those goals (53)
		• **Intermediate values are used as surrogate outcomes of evaluation of the performance of the health system**
		  o Intermediate values are commonly used as dimensions or criteria to evaluate core values like equity or universality (81)

Category & stage		Conditions under which values are used

Technical values	Agenda setting	**Problems**
		• **Technical values are used to frame problems regarding efficiency or financial sustainability**
		  o Governments usually pay attention to problems that are framed in terms of inefficiency or menaces to the fiscal sustainability of the health systems (18–22,32,33,61,70)
		• **Technical values influence the government agenda when a problem puts the economic stability of a health system at risk**
		  o One example is the accumulation of judiciary actions in the Colombian health system (82)

	Policy development and implementation	**Institutions** • **Technical values are used as indicators of policy effectiveness, efficiency, and financial sustainability** o Sometimes, policymakers use indicators of financial protection to evaluate policies focused on achieving equity or universality (83,84)

		Ideas
		• **Technical values are used as pragmatic instruments to inform policy development**
		  o For example, effectiveness and cost-effectiveness have been significant values to make decisions about what drugs or technologies are purchased or covered in Latin American health systems (30,64,65,85)
		• **Technical values are used to determine feasibility of implementing policies, and to prioritize those that are more feasible**
		  o Goals such as universality are broad and complex; technical values help to find how to best achieve this goal by selecting policies that are technically possible and financially feasible (74,86)

Governance	Agenda setting	**Problems** • **Governance values are used to frame problems in terms of corruption, failures in regulation or lack of social participation** o Recently, Latin American countries have come to frame problems of health systems in terms of corruption, lack of social participation or deficiencies in accountability (87)

Category & stage		Conditions under which values are used
		Policies • **Governance values help to gain legitimacy in policy prioritization processes** o When social participation and other governance values are incorporated in the process of prioritization, governments can enhance the legitimacy of their initiatives (88)

	Policy development and implementation	**Institutions**
		
		• **Governance values are typically used late in the process to improve the acceptability of the policy choice**
		  o Social participation is often only considered when policies have been fully developed (e.g., for informing or notifying), and accountability is only considered by the governments as a report presented at the end of the year, which is not subject to auditing and feedback (89)
		• **Governance values are used as strategies against corruption**
		  o Transparency and accountability have begun to appear as essential values for policy implementation processes in health systems,(21,32–35) and they are emphasized as strategies to prevent the corruption (36,37,66)
		• **Governance values are used as indicators of good governance in the health system**
		  o Good governance refers to how authority in the health system is exercised. Those values are used to monitor the performance of the government, and the engagement of the citizens in the policy process (34)

Situational values	**Agenda setting**	**Problems**
		
		• **Situational values are used to frame problems according to specific situational influences**
		  o Situational factors like the promulgation of international policies (e.g., MDGs), might influence how policymakers define problems to be consistent with the discourse of international agencies (e.g., paying attention to problems of maternal and child mortality) (47,70,73)
		• **Situational values influence the government agenda when aligned international influences**
		  o In the 1980s and 90s, “targeting” (i.e., establishing the basic minimum of health services by providing a subsidies with a preference to allocating them to low-income families) became prioritized as an important value to address problems of inequity, given that this value was aligned with the ideas promoted by the World Bank.(17,32,43,50,51,62)

Category & stage	Conditions under which values are used
Policy development and implementation	**Institutions** • **Situational values influence the policy selection when aligned with policy legacies** o Countries that implemented radical health system reforms during 80s and 90s, after intense political changes within the countries have not been able to introduce important transformations in the health system since then due to the strong resource, incentive, and interpretive effects that were created from the original reforms (33) **Interests** • **Situational values influence what policy option is more likely to be chosen when aligned with interest of influential groups** o Policies that align with the interests or values of organized groups (e.g., doctors, patients, private sector) are more likely to be adopted (90) • **Situational values are used as indicators of successful influence of specific groups or ideologies** o Situational values are used to evaluate the success of the government to implement their initiatives, the adoption of foreign policies (policy transfer), the power of some interest groups, and the level of progress in the implementation of a specific model of health system financing (69) **Ideas** • **Situational values influence policy selection when aligned with the ideology of the government (e.g., left vs. right)** o When right-aligned governments prevail, generally health systems are influenced by values such as competitiveness, free choice, market, privatization, and targeting.(39,48,62,91) In countries with left-aligned governments, values such as interculturality, public financing, prevention, and right to health prevail (e.g., Bolivia, Cuba, Ecuador, Venezuela)(41,54–57,69) **External factors** • **Situational values influence the policy selection when aligned with international recommendations or requirements**

Category & stage	Conditions under which values are used
	o Latin America countries have been influenced by international agencies like the World Bank, the International Monetary Fund, WHO, PAHO, and UN. The influence of international agencies has been through a process of policy transfer, sometimes more persuasive and sometimes more coercive, which has resulted in many Latin American countries sharing a number of common characteristics (21,29,43–45,30,32,36,38–42) • **Situational values are used to prioritize policies to be implemented when aligned with specific situational influences** o Perhaps the value that has had the greatest presence in the implementation of health reforms in Latin America has been decentralization, which was one of the key elements of the World Bank recommendations in the 80s and 90s (36,38,50,67)

Appendix 1. Literature search strategy

#	Searches
1	(Latin America or South America or Central America or low-income countries or middle-income countries or Argentin* or Bolivia* or Brazil* or Brasil* or Chile* or Colombia* or Costa Rica* or Cuba* or Ecuador or El Salvador or Guatemala or Haiti or Honduras or Mexic* or Nicaragua* or Panama or Paraguay* or Peru or Dominican Republic or Uruguay* or Venezuel*).af.
2	(((health adj system* adj financing).af. or financing.mp.) adj arrangement*.af.) or financing.af. or financia* adj en salud or financiamiento*.af. [mp=title, original title, abstract, name of substance word, subject heading word]
3	(value* or principle* or goal*).af. or social values[MeSH Major Topic] or (valores* or principios* or valores sociales MeSH or metas*).af.
4	1 and 2 and 3

Appendix 2. List and reasons for articles excluded

Values not on meso or macro scale

#	Reference
1	AHC MediaHIV/AIDS response differs among Latin American countries: some nations offer antiretrovirals; others cannot afford drug treatments. AIDS Alert. 2000;15(5):Online: https://www.ahcmedia.com/articles/58233-aids-alert-international-hiv-aids-response-differs-among-latin-american-countries.
2	Alkenbrack S, Chaitkin M, Zeng W, Couture T, Sharma S. Did equity of reproductive and maternal health service coverage increase during the MDG era? An analysis of trends and determinants across 74 low-and middle-income countries. PLoS ONE. 2015;10(9):e0134905.
3	Almeida G, Sarti FM. Measuring evolution of income-related inequalities in health and health care utilization in selected Latin American and Caribbean countries. Revista Panamericana de Salud Publica. 2013;33(2):83-89.
4	Alvarado-B E, Zunzunegui MV, Béland F, Sicotte M, Tellechea L. Social and gender inequalities in depressive symptoms among urban older adults of Latin America and the Caribbean. Journals of Gerontology Series B: Psychological Sciences & Social Sciences. 2007;62(4):S226-36.
5	Anderson I, Maliqi B, Axelson H, Ostergren M. How can health ministries present persuasive investment plans for women's, children's and adolescents' health? Bulletin of the World Health Organization. 2016;94(6):468-474.
6	Anonymous.In both Venezuela and Peru, 'simplified medicine' is goal. Hospital Practice. 1976;11(10):152-155-157.
7	Arza C. Pension Reforms in Latin America: Distributive Principles, New Inequalities, and Policy Options. Desarrollo Económico. 2009;49(195):363-388.
8	Asemota OA, Klatsky P. Access to infertility care in the developing world: the family promotion gap. Seminars in Reproductive Medicine. 2015;33(1):17-22.
9	Atun R, Knaul FM, Akachi Y, Frenk J. Innovative financing for health: what is truly innovative? Lancet. 2012;380(9858):2044-2049.
10	Baechler R. [The cost of primary health care. Administrative prices versus real costs]. Revista Medica De Chile. 1994;122(10):1207-1216.
11	Bahr J and Wehrhahn R. Life expectancy and infant mortality in Latin America. Social Science & Medicine. 1993;36(10):1373-1382.

12	Banke-Thomas AO, Madaj B, Charles A, van den Broek N. Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review. BMC public health. 2015;15():582.
13	Bárcena A. Health protection as a citizen's right. Lancet. 2015;385(9975):e29-30.
14	Basu S, Stuckler D, McKee M. An alternative mechanism for international health aid: evaluating a Global Social Protection Fund. Health Policy and Planning. 2014;29(1):127-136.
15	Baulch B. Aid distribution and the MDGs. World Development. 2006;34(6):933-950.
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171	Brindis CD, Newacheck PW, Halfon, N, Hughes DC. Improving children's access to health care: The role of decategorization. Bulletin of the New York Academy of Medicine. 1996;73(2):237-254.
172	Frenk J. Dimensions of health system reform. Health Policy. 1994;27(1):19-34.
173	Frenk J. The public-private Mix and Human-resources for Health. Health Policy and Planning. 1993;8(4):315-326.
174	Godal T. Opinion: do we have the architecture for health aid right? Increasing global aid effectiveness. Nature Reviews Microbiology. 2005;3(11):899-903.

175	Lundberg O, Åberg YM, Kölegård SM, Elstad JI, Ferrarini T, Kangas O, Norström T, Palme J Fritzell ,the NEWS Nordic Expert GroupThe role of welfare state principles and generosity in social policy programmes for public health: an international comparative study. Lancet. 2008;372(9650):1633-1640.
176	Mate KS, Rooney AL, Supachutikul A, Gyani G.Accreditation as a path to achieving universal quality health coverage. Globalization and Health. 2014;10():68.
177	Meda ZC, Konate L, Ouedraogo H, Sanou M, Hercot D, Sombie I. Leadership and vision in the improvement of universal health care coverage in low-income countries. Cahiers Sante. 2011;21(3):178-184.
178	Nijmeijer KJ, Fabbricotti IN, Huijsman R. Is franchising in health care valuable? A systematic review. Health Policy and Planning. 2014;29(2):164-176.
179	Peters DH, Paina L, Bennett S. Expecting the unexpected: applying the Develop-Distort Dilemma to maximize positive market impacts in health. Health Policy and Planning. 2012;27():44-53.
180	Sekabaraga C, Diop F, Soucat A. Can innovative health financing policies increase access to MDG-related services? Evidence from Rwanda. Health policy and planning. 2011;26():ii52-62.
181	Shaw D, Cook RJ. Applying human rights to improve access to reproductive health services. International Journal of Gynecology and Obstetrics. 2012;119(Suppl 1):S55-9.
182	Waitzkin H, Yager J, Santos R. Advancing the business creed? The framing of decisions about public sector managed care. Sociology of Health & Illness. 2012;34(1):31-48.
183	Walt G and Buse K. Aid coordination for health sector reform: a conceptual framework for analysis and assessment. Health Policy (Amsterdam, Netherlands). 1996;38(3):173-187.
184	Weaver JL. Reducing health care costs: responses of a multiethnic population. Inquiry. 1972;9(4):20-7.
185	Witter S, Fretheim A, Kessy FL, Lindahl AK. Paying for performance to improve the delivery of health interventions in low- and middle-income countries. Cochrane Database of Systematic Reviews. 2012;(2):84.

Appendix 3. Conceptual mapping according Kingdon's Framework and 3Is Framework

<table>
<tr><th>Dependent variables</th><th>Independent variables</th><th>Data extraction question[s]</th></tr>
<tr><td rowspan="3">Government agendas [i.e., how do values play a role in determining which issues governments decide to take action on health system financing]</td><td>Problem</td><td>Explain whether and how the paper offers insights about the role of values into the prioritization of some problems related to the health system financing:
• focusing event;
• change in an indicator; or
• feedback from the operation of a current program or policy.</td></tr>
<tr><td>Policies/ solutions</td><td>Explain whether and how the paper offers insights about the role of values into the selection of some policies/solutions over others to solve problems of health systems financing:
• diffusion of ideas;
• feedback from the operation of an existing policy or program;
• communication/persuasion;
• whether the policy viewed as technically feasible;
• if the policy fits with the dominant values and current national mood; or
• if it is acceptable in terms of current budget workability or likely political opposition or support.</td></tr>
<tr><td>Politics</td><td>Explain whether and how the paper offers insights about the role of values into the shaping of political factors that determine whether a government prioritize some issues of health system financing over others:
• swings in national mood;
• change in the balance of organized forces; or
• events within government</td></tr>
</table>

<table>
<tr><th>Dependent variables</th><th>Independent variables</th><th>Data extraction question[s]</th></tr>
<tr><td rowspan="3">Policy development [i.e., how do values play a role in current policy decisions about health systems financing]</td><td>Institutions</td><td>Explain whether and how the paper offers insights about the role of values in shaping the structure of health system financing related to:
• government structures [e.g., federal versus unitary government];
• policy legacies [e.g., key past policies that facilitate and/or constrain future policy]; or
• policy networks [e.g., executive council-appointed committees that involve a small number of key stakeholders vs. several arms-length interest groups each vying for the attention of political elites but with no formalized networks in place].</td></tr>
<tr><td>Interests</td><td>Explain whether and how the paper offers insights about the role of values into what interest groups pursue or how they influence decisions about health system financing related to:
• types of interest groups that may be involved [e.g., societal interest groups, elected officials, civil servants or researchers];
• the specific interests in health system financing that each group may have; and
• the influence/power each group might be able to wield.</td></tr>
<tr><td>Ideas</td><td>Explain whether and how the paper offers insights about the role of public values influencing decisions on health system financing related to:
• knowledge/beliefs about ‘what is’ [e.g., research knowledge]; and
• views about ‘what ought to be’ [e.g., values].</td></tr>
<tr><td>Health system context [cross-cutting variables]</td><td>Financial arrangements</td><td>Explain whether and how the paper offers insights about the role of values informing decisions related to:
• financing systems [i.e., mechanisms used to raise revenue for a particular health system];
• funding organizations [i.e., mechanisms used to pay for/purchase services from healthcare organizations within a health system];
• remunerating providers [i.e., mechanisms used to pay for/purchase services from, individual providers within a health system];
• purchasing products and services [i.e., mechanisms used to pay for/purchase products and services]; or</td></tr>
</table>

Dependent variables	Independent variables	Data extraction question[s]
		• incentivizing consumers [i.e., financial or non-financial mechanisms to change specified behaviours of those who receive care].
	Governance arrangements	Explain whether and how the paper offers insights about the role of values informing decisions related to: • policy authority (i.e., who makes policy decisions, how, using what types of frameworks, and on what terms); • organizational authority (i.e., who makes organizational decisions, how, using what types of frameworks, and on what terms); • commercial authority (i.e., who makes commercial decisions, how, using what types of frameworks, and on what terms); • professional authority (i.e., who makes professional decisions, how, using what types of frameworks, and on what terms); or • consumer & stakeholder involvement (i.e., how stakeholders are involved and on what terms).

Appendix 4. Characteristics of all papers included

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
1	J. L. García-Gutiérrez, "Health Planning in Latin America," AJPH, vol. 65, no. 10, pp. 1047–1049, 1975.	English	History of health planning in Latin America	El Salvador, Argentina, Bolivia, Brazil, Chile, Colombia, Peru, Venezuela	No	Discussion paper	efficiency, planning	Y
2	J. A. Walsh and K. S. Warren, "Selective primary health care: an interim strategy for disease control in developing countries," *Soc Sci Med*, vol. 14 C, pp. 145–163, 1980.	English	Primary health care and public health in developing countries	Latin America	No	Discussion paper	Accessibility, Cost-effectiveness, primary healthcare, planning, efficacy, feasibility	N
3	A. Ugalde, "Physicians' control of the health sector: professional values and economic interests. Findings from the Honduran health system," *Soc Sci Med*, vol. 14A, no. 5, pp. 435–444, 1980.	English	Physicians values, interests and control of the health system	Honduras	No	Discussion paper	planning, professional autonomy	Y
4	J. Castellanos Robayo and M. Kisil, "Estructura de los servicios de atención médica.," *Educ Med Salud*, vol. 15, no. 3, pp. 258–290, 1981.	Spanish	Structure of health services	Latin America	No	Stakeholder input	universality, social justice, equity, efficiency, social participation, free choice, accessibility, rationing, quality	Y
5	L. C. G. Lobo, "Sistema de Saúde. Análise e propostas," Educ Med Salud, vol. 20, no. 2, pp. 222–234, 1986.	Portuguese	Health systems analysis and proposals	Brazil	No	Discussion paper	universality, efficiency, equality, social participation, decentralization, intersectorality, rationing, quality, hierarchization	Y
6	M. C. Troncoso, S. Belmartino, C. Bloch, and I. Luppi, "El mercado de trabajo médico y la producción de servicios de salud en la Argentina," Educ Med Salud, vol. 20, no. 4, pp. 535–558, 1986.	Spanish	The medical job market	Argentina	No	Theory paper	medical autonomy	N
7	P. Musgrove, "The economic crisis and its impact on health and health care in Latin America and the Caribbean," Int. J. Health Serv., vol. 17, no. 3, pp. 411–441, 1987.	English	The economic crises and effects on health in Latin America	Latin America	No	Situation analysis	sustainability	N
8	J. L. Fiedler, "Recurrent cost and public health care delivery: the other war in El Salvador," Soc. Sci. Med., vol. 25, no. 8, pp. 867–874, 1987.	English	Cost of health delivery	El Salvador	Yes	Case study	equity, efficiency, effectiveness, quality, simplicity, comfort	Y
9	L. M. Morgan, "Health without wealth? Costa Rica's health system under economic crisis," J. Public Health Policy, vol. 8, no. 1, pp. 86–105, 1987.	English	Effects of economic crisis on health system Costa Rica	Costa Rica	No	Situation analysis	universality, equality, equity, accessibility, "structured cross-class redistribution", primary healthcare, country sovereignty, austerity, market competition	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
10	R. M. Garfield, “War-related changes in health and health services in Nicaragua,” Soc. Sci. Med., vol. 28, no. 7, pp. 669–676, 1989.	English	Effects of the war on the health system in Nicaragua	Nicaragua	No	Situation analysis	Accessibility, availability	N
11	T. J. Bossert, “Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa.,” Soc. Sci. Med., vol. 30, no. 9, pp. 1015–1023, 1990.	English	Sustainability of health programs after donor supports stop	Honduras, Nicaragua	No	Jurisdiction review	social participation, sustainability, effectiveness	N
12	L. M. Morgan, “International politics and primary health care in Costa Rica,” Soc. Sci. Med., vol. 30, no. 2, pp. 211–219, 1990.	English	Participation in primary health in Costa Rica	Costa Rica	No	Situation analysis	social participation, primary-care	Y
13	R. L. Robertson, C. E. Castro, L. C. Gómez, G. Gwynne, C. L. Tinajero Baca, and D. K. Zschock, “La Atención Primaria de Salud en el Ecuador: Los servicios del Ministerio de Salud y de la Seguridad Social Rural,” Bol Sanit Panam, vol. 111, no. 4, pp. 293–305, 1991.	Spanish	Financing of primary health care in Ecuador	Ecuador	Yes	Case study	equity, quality	N
14	C. Puentes-Markides, “Women and access to health care.,” Soc. Sci. Med., vol. 35, no. 4, pp. 619–626, 1992.	English	Women accessibility to health in Latin America	Latin America	No	Discussion analysis	equity, acceptability, accessibility, accountability, affordability, accommodation, gender equality	N
15	J. Frenk and M. A. Gonzalez-Block, “Primary care and reform of health systems: A framework for the analysis of Latin American experiences,” Heal. Serv. Manag. Res., vol. 5, no. 1, pp. 32–43, 1992.	English	Health reforms and primary health care in Latin America	Latin America	No	Framework	universality, efficiency, sustainability, decentralization, accessibility, primary-care, redistribution, integration, pluralism, quality, sustainability	Y
16	M. Vargas-Fuentes, “Privatización de servicios públicos. El caso de los servicios de salud en Costa Rica,” Salud Publica Mex., vol. 35, no. 2, pp. 186–193, 1993.	Spanish	Privatization of health services in Costa Rica	Costa Rica	No	Stakeholder position paper	universality, solidarity, social justice, equity, efficiency, social participation, decentralization, integrality, privatization, quality, compulsoriness	Y
17	H. Novaes, “Hospital trends in Latin America.,” World Health, vol. 47, no. 5, pp. 15–16, 1994.	English	Hospitals in the market of private insurance in Brazil	Brazil	No	Commentary	efficiency, privatization, quality	N
18	J. Frenk, “Comprehensive policy analysis for health system reform.,” Health Policy (New. York)., vol. 32, no. 1, pp. 257–277, 1995.	English	Health system reform in Mexico	Mexico	Yes	Case study	universality, solidarity, equity, efficiency, free choice, citizenship, pluralism, quality	Y
19	L. Lauwers, “Rawlsian equity and generalised utilitarianism with an infinite population ,” Econ. Theory, vol. 9, no. 1, pp. 143–150, 1996.	English	Rawlsian and utilitarian equity	Latin America	No	Theory paper	justice, equity	Y
20	E. Barillas, “La fragmentación de los sistemas nacionales de salud,” Rev Panam Salud Publica, vol. 1, no. 3, pp. 246–249, 1997.	Spanish	Fragmentation of health systems in LA	Latin America	No	Commentary	solidarity, equity, efficiency, decentralization, targeting	N
21	P. E. Brodwin, “Politics, practical logic, and primary health care in rural Haiti,” Med. Anthropol. Q., vol. 11, no. 1, pp. 69–88, 1997.	English	Primary health care in Haiti	Haiti	No	Commentary	social participation, primary healthcare, planning	N
22	F. Rojas-Ochoa and C. M. López-Pardo, “Economy, politics, and health status in Cuba,” Int. J. Heal. Serv., vol. 27, no. 4, pp. 791–807, 1997.	English	Financing decisions of the health system in Cuba	Cuba	No	Situation analysis	universality, efficiency, equality, decentralization, rationality, primary healthcare, planning	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
23	S. Russell and L. Gilson, “User fee policies to promote health service access for the poor: a wolf in sheep’s clothing?” Int. J. Heal. Serv., vol. 27, no. 2, pp. 359–379, 1997.	English	User fees in low- and middle-income countries	Latin America	Yes	Cross-sectional	equity, efficiency, decentralization, acceptability, accessibility, utilization, quality, transparency, acceptability, indigeneity, protection women and children	Y
24	J. M. Paganini, “La cobertura de la atención de salud en América Latina y el Caribe,” Rev. Panam. Salud Publica, vol. 4, no. 5, pp. 305–310, 1998.	Spanish	Health reforms and health coverage in LA	Latin America	Yes	Cross-sectional	equity, efficiency, accessibility, quality, primary healthcare	N
25	Y. Madrid, G. Velásquez, and E. Fefer, “The economics of pharmaceuticals and health sector reform in the Americas,” Pan Am J Public Heal., vol. 3, no. 5, pp. 343–350, 1998.	English	Pharmaceuticals and health reforms in Latin America	Latin America	No	Discussion paper	universality, solidarity, equity, efficiency, social participation, free choice, transparency, decentralization, availability, accessibility, liberalization, quality, affordability, rationality, cost-effectiveness	Y
26	AHRQ, “Managed care has spread from the United States to Latin America with an uncertain effect on quality and access to care.,” Agency for Healthcare Research and Quality, 1999. [Online]. Available: https://archive.ahrq.gov/research/jun99/ra20.htm#head1.	English	Impact of managed care on quality and access in LA	Latin America	No	Commentary	market	N
27	C. Vergara, “El contexto de las reformas del sector de la salud,” Rev. Panam. Salud Publica, vol. 8, no. 1, pp. 7–12, 2000.	Spanish	The context of health system reforms in LA	Latin America	No	Discussion paper	equity, efficiency, social participation, decentralization, competitiveness, targeting, autonomy	N
28	R. Molina, M. Pinto, P. Henderson, and C. Vieira, “Gasto y financiamiento en salud: situación y tendencias,” Rev. Panam. Salud Publica/Pan Am. J. Public Heal., vol. 8, no. 1, pp. 71–83, 2000.	Spanish	Health expenditure and financing in LA	Latin America	No	Situation analysis	equity, efficiency, sustainability, accessibility, privatization	N
29	I. M. Parada, P. Hernández, A. Arredondo, and F. Becerra, “Financiamiento de programas de farmacodependencia en la ciudad de México: 1990-1994,” Salud Publica Mex., vol. 42, no. 2, pp. 118–125, 2000.	Spanish	Financing of programs of drug abuse in Mexico	Mexico	Yes	Cross-sectional	efficiency, self-management, privatization	N
30	C. Celedón and M. Noé, “Reformas del sector de la salud y participación social,” Rev. Panam. Salud Publica, vol. 8, no. 1, pp. 99–104, 2000.	English	Social participation and health system reforms	Latin America	No	Discussion paper	equity, efficiency, social participation, free choice, timely access, efficacy, centralization, quality	N
31	A. Infante, I. de la Mata, and D. Lopez-Acuna, “Reforma de los sistemas de salud en America Latina y el Caribe: situacion y tendencias,” Rev Panam Salud Publica, vol. 8, no. 1, pp. 13–20, 2000.	Spanish	Health systems reforms in Latin America	Latin America	No	Situation analysis	equity, efficiency, social participation, sustainability, decentralization, effectiveness, quality	Y
32	T. J. Bossert et al., “Applied research on decentralization of health systems in Latin America: Colombia case study,” 2000.	English	Decentralization in LA	Bolivia, Chile	Yes	Comparative policy analysis	equity, efficiency, decentralization, accessibility, coverage, quality, financial soundness	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
33	J. L. Fiedler and J. B. Wight, "Financing health care at the local level: the community drug funds of Honduras," Int J Heal. Mgmt, vol. 15, no. 4, pp. 319–340, 2000.	English	Financing drug funds at local level in Honduras	Honduras	Yes	Cross-sectional	social participation, accessibility, rationality	N
34	C. Collins, J. Araujo, and J. Barbosa, "Decentralising the health sector: issues in Brazil," Health Policy (New. York)., vol. 52, no. 2, pp. 113–127, 2000.	English	Decentralization in Brazil	Brazil	No	Situation analysis	universality, equity, decentralization, public-financing	Y
35	A. Ross, J. Zeballos, and A. Infante, "La calidad y la reforma del sector de la salud en América Latina y el Caribe," Rev. Panam. Salud Publica, vol. 8, no. 1, pp. 93–98, 2000.	Spanish	Quality and health system reform	Latin America	No	Discussion paper	equity, efficiency, social participation, sustainability, Quality, Effectiveness	N
36	G. González García, "Las reformas sanitarias y los modelos de gestión," Rev. Panam. Salud Pública, vol. 9, no. 6, pp. 406–412, 2001.	Spanish	Health sector reform and management models	Latin America	No	Discussion paper	universality, equity, free choice, decentralization, autonomy, competitiveness, management, targeting, rationing, productivity	Y
37	M. Schlesser and B. Puertas, "Assessing community health among indigenous populations in Ecuador with a participatory approach: implications for health reform," J. Community Health, vol. 26, no. 2, pp. 133–147, 2001.	English	Indigenous communities and health reform in Ecuador	Ecuador	Yes	Cross-sectional	equity, efficiency, protection of indigenous people, quality	N
38	C. Almeida, "Reforma de sistemas de servicios de salud y equidad en América Latina y el Caribe: algunas lecciones de los años 80 y 90," Cad Saüde Pública, vol. 18, no. 4, pp. 905–925, 2002.	Spanish	Equity and health systems reform in Latin America	Latin America	No	Discussion paper	universality, solidarity, equity, equality, social participation, free choice, decentralization, cost-containment, right, management, competitiveness, market, efficacy, privatization, targeting	Y
39	S. M. Porto, "Equidad y distribución geográfica de recursos financieros en los sistemas de salud," Cad. Saude Publica, vol. 18, no. 4, pp. 939–957, 2002.	Spanish	Equity and geographic distribution of financial resources in the Brazilian health system	Brazil	No	Performance review	universality, social justice, equity	N
40	N. Homedes and A. Ugalde, "Privatización de los servicios de salud: las experiencias de Chile y Costa Rica," Gac Sanit, vol. 16, no. 1, pp. 54–62, 2002.	Spanish	Privatization of health services in Costa Rica and Chile	Costa Rica, Chile	Yes	Comparative situation analysis	solidarity, equity, efficiency, decentralization, privatization	N
41	I. Vargas, M. L. Vazquez, and E. Jane, "Equidad y reformas de los sistemas de salud en Latinoamerica," Cad. Saude Publica, vol. 18, no. 4, pp. 927–937, 2002.	Spanish	Equity in health systems reform in Colombia and Costa Rica	Costa Rica, Colombia	No	Jurisdictional review	universality, solidarity, equity, efficiency, equality, free choice, efficacy, targeting, individualism	Y
42	Ó. Arteaga, S. Thollaug, A. C. Nogueira, and C. Darras, "Información para la equidad en salud en Chile," Rev. Panam. Salud Publica/Pan Am. J. Public Heal., vol. 11, no. 5, pp. 374–385, 2002.	Spanish	Equity in health care in Chile	Chile	Yes	Cross-sectional	equity, decentralization	N
43	J. H. Bratt, M. A. Weaver, J. Foreit, T. de Vargas, and B. Janowitz, "The impact of price changes on demand for family planning and reproductive health services in Ecuador," Health Policy Plan., vol. 17, no. 3, pp. 281–287, 2002.	English	Effects of prices change over reproductive services utilization in Ecuador	Ecuador	Yes	Randomized Controlled Trial	sustainability, accessibility,	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
44	R. A. Castano-Yepes, J. J. Arbelaez, U. B. Giedion, and L. G. Morales, "Equitable financing, out-of-pocket payments and the role of health care reform in Colombia," Health Policy Plan., vol. 17, no. Suppl 1, pp. 5–11, 2002.	English	Equitable financing and out-of-pocket expenditure in Colombia	Colombia	Yes	Interrupted time series	equity, efficiency, fairness, progressiveness, regresiveness	N
45	G. Alleyne, "Equity and the goal of Health for All," Rev. Panam. Salud Publica, vol. 11, no. 5/6, pp. 297–301, 2002.	English	Equity	Latin America	No	Commentary	equity, right	N
46	E. Gómez-Gómez, "Equidad de género en las políticas de reforma del sector de la salud de América Latina y el Caribe," Rev. Panam. Salud Publica/Pan Am. J. Public Heal., vol. 11, no. 5–6, pp. 435–438, 2002.	Spanish	Equity and gender in the LA	Latin America	No	Government strategic plan for the health sector	Equity, gender equity	N
47	E. Gómez-Gómez, "Equidad, género y salud: retos para la acción," Rev Panam Salud Publica, vol. 11, no. 5, pp. 435–438, 2002.	Spanish	Equity and gender in Latin America's health systems	Latin America	No	Discussion paper	social justice, equity, social participation, gender-perspective	Y
48	R. M. Marques and A. Mendes, "A política de incentivos do Ministério da Saúde para a atenção básica: uma ameaça à autonomia dos gestores municipais e ao princípio da integralidade?," Cad. Saude Publica, vol. 18, no. Supl, pp. 163–171, 2002.	Portuguese	Health financing in Brazil, conflicts between federal and municipal policies	Brazil	No	Situation analysis	universality, decentralization, integrality, Rationing, prioritization, right to health	N
49	J. Dachs, M. Ferrer, C. Florez, A. Barros, R. Narváez, and M. Valdivia, "Inequalities in health in Latin America and the Caribbean: descriptive and exploratory results for self-reported health problems and health care in twelve countries.," Rev. Panam. Salud Publica, vol. 11, no. 5/6, pp. 335–355, 2002.	English	Health inequalities in LA countries	Latin America	Yes	Cross-sectional	Equity, gender equity	N
50	M. Arretche, "Financiamento federal e gestão local de políticas sociais: o difícil equilíbrio entre regulação, responsabilidade e autonomia," Cien. Saude Colet., vol. 8, no. 2, pp. 331–369, 2003.	Portuguese	Federal financing and local management in Brazil	Brazil	No	Situation analysis	universality, equity, efficiency, decentralization, enforcement of enforcement of regulation, accountability, autonomy, hierarchization	N
51	E. Rosselot, "Aspectos bioéticos comprendidos en la Reforma de la Atención de Salud en Chile. Los problemas del acceso y el costo de los recursos," Rev. Med. Chil., vol. 131, no. 9, pp. 1079–1086, 2003.	Spanish	Bioethical problems of the health system reform in Chile	Chile	No	Discussion paper	universality, solidarity, social justice, equity, free choice, prevention, accessibility, timely access, effectiveness, financial-protection, primary-care, right, rationing	Y
52	A. C. Laurell, "What does Latin American social medicine do when it governs? The case of the Mexico City government," Am. J. Public Health, vol. 93, no. 12, pp. 2028–2031, 2003.	English	The health policy of social medicine in Mexico	Mexico	No	Jurisdictional review	universality, solidarity, equity, decentralization, accessibility, timely access, privatization, market, targeting, cost-efficiency, right	Y
53	M. Romero-González, G. González, and R. A. Rosenheck, "Mental health service delivery following health system reform in Colombia," J. Ment. Health Policy Econ., vol. 6, no. 4, pp. 189–194, 2003.	English	Mental health services with the health system reform in Colombia	Colombia	Yes	Before-after study	universality, efficiency, accessibility, managed competition, structured pluralism, financial autonomy, right to health, affordability	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
54	J. G. Temporão, "O mercado privado de vacinas no Brasil: a mercantilização no espaço da prevenção," Cad. Saude Publica, vol. 19, no. 5, pp. 1323–1339, 2003.	Portuguese	The health policy of social medicine in Mexico	Brazil	Yes	Case study	universality, equity, equality, decentralization, accessibility, social-control, market	Y
55	N. Almeida-Filho, I. Kawachi, A. Filho, and J. Dachs, "Research on health inequalities in Latin America and the Caribbean: bibliometric analysis (1971-2000) and descriptive content analysis (1971-1995)," Am. J. Public Health, vol. 93, no. 12, pp. 2037–2043, 2003.	English	Health inequalities in LA	Latin America	Yes	Qualitative Systematic review	equity	N
56	L. M. Prada, "Aseguramiento en los regímenes Contributivo y Subsidiado, e impacto en los prestadores de servicios," Rev. Salud Publica, vol. 6, no. 1, pp. 1–27, 2004.	Spanish	Effects of health insurance over providers in Colombia	Colombia	No	Performance review	efficiency	N
57	N. Palmer, D. H. Mueller, L. Gilson, A. Mills, and A. Haines, "Health financing to promote access in low income settings-how much do we know?," Lancet, vol. 364, no. 9442, pp. 1365–1370, 2004.	English	Types and characteristics of health system financing in LMIC	Costa Rica, Honduras, Mexico, Brazil, Colombia	Yes	Quantitative systematic review	equity, efficiency, sustainability, accessibility,	N
58	S. Wallace and V. Gutiérrez, "Equity of access to health care for older adults in four major Latin American cities," Rev. Panam. Salud Publica, vol. 17, no. 5/6, pp. 394–409, 2005.	English	Equity in health access for older people in LA	Mexico, Brazil, Chile, Uruguay	Yes	Cross-sectional	equity, availability, acceptability, accessibility	N
59	N. Homedes and A. Ugalde, "Why neoliberal health reforms have failed in Latin America.," Health Policy (New. York)., vol. 71, no. 1, pp. 83–96, 2005.	English	Privatization and decentralization in Colombia and Chile	Chile, Colombia	No	Situation analysis	universality, equity, efficiency, decentralization, privatization, quality, user's satisfaction, accountability	Y
60	N. Homedes, A. Ugalde, and J. R. Forns, "The World Bank, pharmaceutical policies, and health reforms in Latin America," Int. J. Heal. Serv. Planning, Adm. Eval., vol. 35, no. 4, pp. 691–717, 2005.	English	Pharmaceutical policies, world Bank and health systems reform in Latin America	Latin America	No	Discussion paper	decentralization, accessibility, affordability, privatization, targeting, cost-effectiveness, centralization, competitiveness, savings, adequate-use, transparency	Y
61	F. Knaul and J. Frenk, "Health insurance in Mexico: achieving universal coverage through structural reform," Health Aff., vol. 24, no. 6, pp. 1467–1476, 2005.	English	Health insurance and universal coverage in Mexico	Mexico	No	Situation analysis	universality, solidarity, equity, efficiency, sustainability, quality, fairness, right, cost-effectiveness, consumer satisfaction, accountability	Y
62	F. Knaul, H. Arreolo-Ornelas, O. Mendez, and A. Martinez, "Justicia financiera y gastos catastróficos en salud: impacto del Seguro Popular de Salud en Mexico," Salud Publica Mex., vol. 47, no. supl 1, pp. S54–S65, 2005.	Spanish	Financing and social insurance in Mexico	Mexico	Yes	Cross-sectional	universality, equity, efficiency, accessibility, fairness	Y
63	A. Ugalde and N. Homedes, "Las reformas neoliberales del sector de la salud: déficit gerencial y alienación del recurso humano en América Latina," Rev Panam Salud Publica, vol. 17, no. 3, pp. 202–209, 2005.	Spanish	Human resources and health system reforms in LA	Latin America	No	Discussion paper	equity, efficiency, profitability, user-satisfaction, quality, flexibility	N
64	G. Carrin and C. James, "Key performance indicators for the implementation of social health insurance," Appl. Health Econ. Health Policy, vol. 4, no. 1, pp. 15–22, 2005.	English	Performance Indicators for the Implementation of Social Health	Latin America	No	Framework	universality, equity, accessibility, affordability	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
65	A. Arredondo, E. Orozco, and E. De Icaza, "Evidences on weaknesses and strengths from health financing after decentralization: lessons from Latin American countries," Int. J. Health Plann. Manage., vol. 20, no. 2, pp. 181–204, 2005.	English	Insurance in LMICs health financing after decentralization in LA	Mexico, Nicaragua, Peru	Yes	Before-after study Mixed methods	decentralization	Y
66	R. M. Marques and A. Mendes, "SUS e Seguridade Social: em busca do Elo Perdido," Saude e Soc., vol. 14, no. 2, pp. 39–49, 2005.	Portuguese	Financing of social health insurance in Brazil	Brazil	No	Situation analysis	universality	N
67	D. Titelman and A. Uthoff, "The role of insurance in social protection in Latin America," Int. Soc. Secur. Rev., vol. 58, no. 2–3, pp. 43–69, 2005.	English	Reforms in the financing of social security for healthcare and pensions in LA	Latin America	No	Situation analysis	universality, solidarity, equity, efficiency, accessibility, cost-containment, privatization	N
68	M. San Sebastián, A.-K. Hurtig, and K. Rasanathan, "Is trade liberalization of services the best strategy to achieve health-related millennium development goals in Latin America? A call for caution," Rev. Panam. Salud Publica/Pan Am. J. Public Heal., vol. 20, no. 5, pp. 341–346, 2006.	English	Liberalization and MDG in LA	Latin America	No	Discussion paper	Millennium development goals	N
69	R. Urriola, "Chile: Protección social de la Salud," Rev Panam Salud Publica, vol. 20, no. 4, pp. 273–286, 2006.	Spanish	Social protection in health in Chile	Chile	No	Discussion paper	universality, solidarity, equity, equality, social-cohesion, financial-protection, right, targeting, efficacy	Y
70	R. A. Montenegro and C. Stephens, "Indigenous health in Latin America and the Caribbean," Lancet, vol. 367, no. 9525, pp. 1859–1869, 2006.	English	Indigenous communities and health policies in Latin America	Latin America	No	Situation analysis	accessibility, cultural appropriateness, appropriateness, autonomy	Y
71	C. Muntaner, R. M. Guerra-Salazar, S. Rueda, and F. Armada, "Challenging the neoliberal trend: the Venezuelan health care reform alternative.," Can. J. Public Heal., vol. 97, no. 6, p. I-19, 2006.	English	Health system reform in Venezuela	Venezuela	No	Discussion paper	universality, solidarity, social justice, equity, social participation, intersectorality, prevention, accessibility, right, cultural-appropriateness, solidarity	Y
72	P. Lloyd-Sherlock, "When social health insurance goes wrong: Lessons from Argentina and Mexico," Centro Interdisciplinario para el estudio de políticas públicas, Buenos Aires, 56, 2007.	English	Social health insurance in Argentina and Mexico	Mexico, Argentina	No	Situation analysis	solidarity, equity, sustainability, coverage, effectiveness, market, right	Y
73	C. Mesa-Lago, "Social Security in Latin America: Pension and Health Care Reforms in the Last Quarter Century," Lat. Am. Res. Rev., vol. 42, no. 2, pp. 181–201, 2007.	English	Pensions and health care reform in Latin America	Bolivia, Argentina, Brazil, Colombia, Costa Rica, Mexico, Peru, Panama	No	Situation analysis	efficiency, social participation, free choice, decentralization, institutional autonomy, coverage, integration/coordination, competitiveness, privatization, efficiency	Y
74	C. O. Ocke-Reis, "Os desafios da ANS frente à concentração dos planos de saúde," Cienc. e Saude Coletiva, vol. 12, no. 4, pp. 1041–1050, 2007.	Portuguese	Private health plan market in Brazil	Brazil	No	Discussion paper	Competitiveness, enforcement of enforcement of regulation, market	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
75	G. Cruces and D. Titelman, “Challenges for health and social protection in Latin America.,” Glob. Soc. Policy, vol. 7, no. 2, pp. 136–139, 2007.	English	Health and social protection in LA	Latin America	No	Commentary	universality, solidarity, efficiency, inclusiveness, rationality	N
76	C. Botto-Abella and B. Graterol-Mendoza, “Globalización, desigualdad y transmisión de las enfermedades tropicales en el Amazonas venezolano,” Cad. Saude Publica, vol. 23, no. Supl 1, pp. S51-63, 2007.	Spanish	Globalization, inequalities and Indigenous communities in Venezuela	Venezuela	No	Jurisdiction review	equity, decentralization, prevention, integrality, protection of indigenous people, right to health, public financing	N
77	F. Ruiz, L. Amaya, and S. Venegas, “Progressive segmented health insurance: Colombian health reform and access to health services,” Health Econ., vol. 16, no. 1, pp. 3–18, 2007.	English	Segmentation in health insurance in Colombia	Colombia	Yes	Cohort study	universality, solidarity, efficiency, decentralization, accessibility, utilization, coverage, targeting	Y
78	J. Raña K, J.-C. Ferrer O, and P. Bedregal G, “Modelo de asignación de recursos en atención primaria,” Rev. Med. Chil., vol. 135, no. 1, pp. 54–62, 2007.	Spanish	Model for health resource allocation for primary care in Chile	Chile	No	Framework	equity, efficiency, prevention,	N
79	J. J. S. P. Solla, A. A. C. dos Reis, A. P. M. Soter, A. S. Fernandes, and J. J. L. de Palma, “Mudanças recentes no financiamento federal do Sistema Único de Saúde: atenção básica à saúde,” Rev. Bras. Saude Matern. Infant., vol. 7, no. 4, pp. 495–502, 2007.	Portuguese	Public health system federal financing in Brazil	Brazil	No	Discussion paper	equity, decentralization	Y
80	M. E. Kruk, S. Galea, M. Prescott, and L. P. Freedman, “Health care financing and utilization of maternal health services in developing countries,” Health Policy Plan., vol. 22, pp. 303–310, 2007.	English	Health systems financing and access to maternal services in developing countries	Latin America	Yes	Cross-national analysis	Universality, MDG, effectiveness, utilization	Y
81	G. J. Schieber, P. Gottret, L. K. Fleisher, and A. A. Leive, “Financing global health: mission unaccomplished,” Health Aff. (Millwood)., vol. 26, no. 4, pp. 921–934, 2007.	English	Donors and health systems financing in poor countries	Latin America	No	Discussion paper	MDG, accountability	N
82	L. Tafur, “Controversia a la reforma de la Ley 100 de 1993, Ley 1122 de enero de 2007,” Colomb. Med., vol. 38, no. 2, pp. 107–112, 2007.	Spanish	Health system reform in Colombia (Law 1122)	Colombia	No	Discussion paper	universality, social participation, enforcement of enforcement of regulation	N
83	M. R. Bhatia and A. C. Gorter, “Improving access to reproductive and child health services in developing countries: are competitive voucher schemes an option?,” J. Int. Dev., vol. 19, no. 7, pp. 975–981, 2007.	English	Access to reproductive and child services and MDG in developing countries	Latin America	No	Discussion paper	efficiency, free choice, accessibility, MDG, private financing, quality, competitiveness, cost-effectiveness	N
84	I. Torres-Vigil, L. A. Aday, L. de Lima, and C. S. Cleeland, “Wath predicts the quality of advanced cancer care in Latin America? A look at five countries: Argentina, Brazil, Cuba, Mexico, and Peru.,” J. Pain Symptom Manag., vol. 34, no. 3, pp. 315–327, 2007.	English	Predictors of quality in cancer care in Latin America	Cuba, Mexico, Argentina, Brazil, Peru	Yes	Cross-sectional/ Cross-national study	equity, availability, accessibility, quality, affordability	Y
85	A. Arredondo, O, and E. Orozco, “Equity, governance and financing after health care reform: lessons from Mexico,” Int. J. Health Plann. Manage., vol. 23, no. 1, pp. 37–49, 2008.	English	Equity, governance and health system financing in Mexico	Mexico	No	Discussion paper	equity, social participation, decentralization, accountability, democratization, governance	N
86	G. Backman et al., “Health systems and the right to health: an assessment of 194 countries.,” Lancet (London, England), vol. 372, no. 9655, pp. 2047–85, Dec. 2008.	English	Right to health global perspective	Latin America	Yes	Mixed methods	right to health	Y

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87	A. L. D. Viana and C. V. Machado, "Proteção social em saúde: um balanço dos 20 anos do SUS," Physis Rev. Saude Coletiva, vol. 18, no. 4, pp. 645–684, 2008.	Portuguese	Social protection in health in Brazil	Brazil	No	Discussion paper	decentralization, self-financing, private financing, right to health	N
88	M. del P. Guzmán-Urrea, "Deficiencia en los diagnósticos de las reformas sanitarias de los anos noventa en Améica Latina," Rev Panam Salud Publica, vol. 25, no. 1, pp. 84–92, 2009.	Spanish	Equity and health systems reforms in Latin America	Latin America	No	Discussion paper	universality, equity, efficiency, decentralization, rationing, effectiveness, competitiveness, enforcement of enforcement of regulation	Y
89	J. Frenk, O. Gomez-Dantes, and F. M. Knaul, "The democratization of health in Mexico: financial innovations for universal coverage," Bull. World Health Organ., vol. 87, no. 7, pp. 542–548, 2009.	English	Financial innovations and universal coverage in health in Mexico	Mexico	No	Situation analysis	universality, equity, sustainability, availability, democratization, utilization, financial-protection, quality, fair-financing, sufficiency, efficiency, right	Y
90	D. McIntyre, M. Thiede, and S. Birch, "Access as a policy-relevant concept in low- and middle-income countries," Health Econ. Policy. Law, vol. 4, pp. 179–193, 2009.	English	Access concept in health systems	Latin America	No	Framework	availability, acceptability, accessibility, Utilization, affordability, empowerment	N
91	P. McNamee, J. Hussein, and L. Ternent, "Barriers in accessing maternal healthcare: evidence from low-and middle-income countries," Expert Rev. Pharmacoecon. Outcomes Res., vol. 9, no. 1, pp. 41–48, 2009.	English	Allocation of expenditure, MDG and access to maternal and child care in LMICs	Latin America	Yes	Qualitative systematic review	availability, acceptability, MDG, utilization, cost-effectiveness, coverage, quality	N
92	A. D. Oxman and A. Fretheim, "Can paying for results help to achieve the Millennium Development Goals? A critical review of selected evaluations of results-based financing," J. Evid. Based. Med., vol. 2, no. 3, pp. 184–195, 2009.	English	Pay-for-performance and MDG in LMICs	Latin America	Yes	Quantitative systematic review	MDG, effectiveness	N
93	M. Cintra, "Movimentação financeira: a base de uma contribuição para o INSS em substituição à folha de pagamentos," RAP, vol. 44, no. 6, pp. 1477–1506, 2010.	Portuguese	Taxation and social security insurance in Brazil	Brazil	No	Situation analysis	Private financing	N
94	J. M. Lakin, "The End of Insurance? Mexico's Seguro Popular, 2001 - 2007," J. Health Polit. Policy Law, vol. 35, no. 3, pp. 313–352, 2010.	English	Health insurance in Mexico	Mexico	No	Discussion paper	equity, efficiency, competitiveness, coverage, pluralism, market, integration	Y
95	C. Méndez and J. Vanegas, "La participación social en salud: el desafío de Chile," Rev Panam Salud Pública, vol. 27, no. 2, pp. 144–148, 2010.	Spanish	Social participation and health system reform in Chile	Chile	No	Discussion paper	solidarity, equity, efficiency, social participation, decentralization, accessibility, quality, market	N
96	O. Galárraga, S. G. Sosa-Rubí, A. Salinas-Rodríguez, and S. Sesma-Vásquez, "Health insurance for the poor: impact on catastrophic and out-of-pocket health expenditures in Mexico," Eur J Heal. Econ, vol. 11, no. 5, pp. 437–447, 2010.	English	Health insurance and out-of-pocket expenditure in Mexico	Mexico	Yes	Cross-sectional	universality, financial protection, targeting	N
97	M. E. Kruk, D. Porignon, P. C. Rockers, and W. Van Lerberghe, "The contribution of primary care to health and health systems in low- and middle-income countries: a critical review of major primary care initiatives," Soc. Sci. Med., vol. 70, no. 6, pp. 904–911, 2010.	English	Primary care and MDG in LMICs	Latin America	Yes	Qualitative systematic review	equity, efficiency, continuity, accessibility, MDG, primary-care, responsiveness, financial-protection, effectiveness, health-system-strengthening	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
98	R. Fryatt, A. Mills, and A. Nordstrom, "Financing of health systems to achieve the health Millennium Development Goals in low-income countries," Lancet (London, England), vol. 375, no. 9712, pp. 419–426, 2010.	English	Health systems financing and MDG in LMICs	Latin America	No	Government strategic plan for the health sector	universality, accountability	Y
99	N. Krieger et al., "Who, and what, causes health inequities? Reflections on emerging debates from an exploratory Latin American/North American workshop.," J. Epidemiol. Community Heal., vol. 64, no. 9, pp. 747–749, 2010.	English	Health inequalities in LA countries	Latin America	No	Stakeholder input	equality	N
100	C. F. Cáceres et al., "Implementation effects of GFATM-supported HIV/AIDS projects on the health sector, civil society and affected communities in Peru 2004-2007," Glob. Public Health, vol. 5, no. 3, pp. 247–265, 2010.	English	Donations and health financing for AIDS, Malaria and TB in Peru	Peru	Yes	Case study	equity, accessibility, Accountability, financial-protection	N
101	S. Segall, "Is health (Really) Special? Health Policy between Rawlsian and Luck Egalitarian Justice," J. Appl. Philos., vol. 27, no. 4, pp. 344–58, 2010.	English	Rawlsian and egalitarian justice	Latin America	No	Theory paper	justice, equity	Y
102	A. Stolkiner, "Derechos humanos y derecho a la salud en América Latina: la doble faz de una idea potente," Med. Soc., vol. 5, no. 1, pp. 89–95, 2010.	Spanish	Right to health in LA	Latin America	No	Discussion paper	right to health	Y
103	I. Vargas, M. L. Vásquez, A. S. Mogollón-Pérez, and J.-P. Unger, "Barriers of access to care in a managed competition model: lessons from Colombia," BMC Health Serv. Res., vol. 10, p. 297, 2010.	English	Managed care and access to health services in Colombia	Colombia	Yes	Case study	equity, efficiency, accessibility, Market, financial-protection, sustainability, profitability	N
104	T. M. Gonçalves Menicucci, "A Política de Saúde no Governo Lula," Saude E Soc., vol. 20, no. 2, pp. 522–532, 2011.	Portuguese	The health policy in Brazil	Brazil	No	Government position paper	efficiency, integrality, accessibility, coverage, quality, focalization, private, gender-equity	N
105	J. R. M. de França and N. do R. Costa, "A dinâmica da vinculação de recursos para a saúde no Brasil: 1995 a 2004," Cienc. e Saude Coletiva, vol. 16, no. 1, pp. 241–257, 2011.	Portuguese	Binding resources for financing health in Brazil	Brazil	No	Performance review	efficiency, sustainability, coverage, sufficiency	N
106	G. Z. Portela and J. M. Ribeiro, "A sustentabilidade econômico-financeira da Estratégia Saúde da Família em municípios de grande porte," Cienc. e Saude Coletiva, vol. 16, no. 3, pp. 1719–1732, 2011.	Portuguese	Financial sustainability of the Family Health Strategy in Brazil	Brazil	Yes	Cohort study	universality, sustainability	N
107	A. C. G. do E. Santo and O. Y. Tanaka, "Financiamento, gasto e oferta de serviços de saúde em grandes centros urbanos do estado de São Paulo (Brasil)," Cien. Saude Colet., vol. 16, no. 3, pp. 1875–1885, 2011.	Portuguese	Health care financing and expenditure in Brazil	Brazil	Yes	Cohort study	equity, decentralization	N
108	L. Huamán-Angulo, L. Liendo-Lucano, and M. Núñez-Vergara, "Plansalud: Plan sectorial concertado descentralizado para el desarrollo de capacidades en salud, Perú 2010-2014," Rev Peru Med Exp Salud Publica, vol. 28, no. 2, pp. 362–371, 2011.	Spanish	Descentralization and health plan for Peru	Peru	No	Government strategic plan for	equity, efficiency, decentralization, accessibility, quality, multiculturalism, relevance,	N

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						the health sector		
109	R. Uauy, "The impact of the Brazil experience in Latin America.," Lancet, vol. 377, no. 9782, pp. 1984–1986, 2011.	English	Brazilian health system experience	Brazil	No	Commentary	universality, accessibility, effectiveness	N
110	K. Artaraz, "New Latin American networks of solidarity? ALBA's contribution to Bolivia's National Development Plan (2006-10)," Glob. Soc. Policy, vol. 11, no. 1, pp. 88–105, 2011.	English	Solidarity networks and health policy in Bolivia	Bolivia	No	Stakeholder input	universality, solidarity, social justice, fairness	Y
111	N. B. Sugiyama, "The diffusion of Conditional Cash Transfer programs in the Americas.," Glob. Soc. Policy, vol. 11, no. 2–3, pp. 250–278, 2011.	English	Conditional cash transfer, policy diffusion in the Americas	Latin America	No	Situation analysis	efficiency, effectiveness	N
112	F. Augustovski, S. Garcia Marti, A. Pichon Riviere, and A. Rubinstein, "Universal coverage with rising healthcare costs; health outcomes research value in decision-making in Latin America," Expert Rev. Pharmacoeconomics Outcomes Res, vol. 11, no. 6, pp. 657–659, 2011.	English	Universal coverage with healthcare costs rising in Latin America	Latin America	No	Stakeholder input	universality, efficiency, accessibility, financial-protection, cost-effectiveness, affordability	Y
113	E. R. Smith et al., "Cost-Effectiveness of Rotavirus Vaccination in Bolivia from the State Perspective," Vaccine, vol. 29, no. 38, pp. 6704–6711, 2011.	English	Cost-effectiveness of vaccination in Bolivia	Bolivia	Yes	Cost-effectiveness study	cost-effectiveness	N
114	R. D. L. Ríos, C. Arósquipa, and W. Vigil-Oliver, "El financiamiento internacional para la cooperación al desarrollo de la salud de América Latina y el Caribe," Rev. Panam. Salud Publica, vol. 30, no. 2, pp. 133–143, 2011.	Spanish	Donations (international cooperation) and health financing in LA	Latin America	Yes	Cross-sectional	efficacy, MDG	N
115	A. Mendes, M. G. Leite, and R. M. Marques, "Discutindo uma Metodologia para a Alocação Equitativa de Recursos Federais para o Sistema Único de Saúde," Saude E Soc., vol. 20, no. 3, pp. 673–690, 2011.	Portuguese	Resource allocation in the health system of Brazil	Latin America	No	Stakeholder input	universality, efficiency, accessibility, financial-protection, cost-effectiveness, affordability	Y
116	L. G. Queiroz and L. Giovanella, "Agenda regional da saúde no Mercosul: arquitetura e temas," Rev. Panam. Salud Publica, vol. 30, no. 2, pp. 182–188, 2011.	Portuguese	Health agenda for Mercosur countries	Argentina, Brazil, Paraguay, Uruguay, Venezuela	No	Government strategic plan for the health sector	equity, integration, mobility	N
117	A. Flores et al., "Advocacy and resource mobilization for rubella elimination in Guatemala," J. Infect. Dis., vol. 204, no. Suppl 2, pp. S598-602, 2011.	English	Resource mobilization to vaccination in Guatemala	Guatemala	Yes	Economic evaluation Mixed methods	cost-effectiveness	N
118	J. D. Kraemer, O. A. Cabrera, J. A. Singh, T. B. Depp, and L. O. Gostin, "Public health measures to control tuberculosis in low-income countries: ethics and human rights considerations," Int J Tuberc Lung Dis, vol. 15, no. 6, pp. S19-24, 2011.	English	Ethics, human rights and control TB in LMICs	Latin America	No	Discussion paper	accessibility, reasonableness, effectiveness, proportionality, reciprocity, distributive-justice, trust, transparency	N

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119	V. R. Leite, C. M. de Vasconcelos, and K. C. Lima, "Federalism and decentralization: impact on international and Brazilian health policies," Int. J. Heal. Serv., vol. 41, no. 4, pp. 711–723, 2011.	English	Federalism and decentralization in the health system of Brazil	Brazil	No	Jurisdictional review	decentralization	N
120	C. Franco-Paredes, I. Hernández-Ramos, J. I. Santos-Preciado, and Grupo de Trabajo en Inmunizaciones del Sistema Mesoamericano de Salud Pública, "Inmunizaciones y equidad en el Plan Regional del Sistema Mesoamericano de Salud Pública," Salud Publica Mex., vol. 53, no. Supl 3, pp. S323-332, 2011.	Spanish	Equity and immunization in Mesoamerica	Latin America	No	Stakeholder input	equity, social participation, protection of indigenous people, coverage, efficacy, cultural appropriateness, evidence-based	N
121	G. T. B. Araujo, J. E. Caporale, S. Stefani, D. Pinto, and A. Caso, "Is equity of access to health care achievable in Latin America?," Value Heal., vol. 14, no. 5, pp. S8-12, 2011.	English	Equity in access to health in Latin America	Mexico, Argentina, Brazil, Colombia	No	Discussion paper	universality, equity, efficiency, transparency, accessibility, interculturality, financial-protection, evidence-based, market	Y
122	A. D. Bertoldi et al., "Household expenditures for medicines and the role of free medicines in the Brazilian public health system," Am. J. Public Health, vol. 101, no. 5, pp. 916–921, 2011.	English	Household expenditure for medicines in Brazil	Brazil	Yes	Cross-sectional	Public financing	N
123	R. J. F. Esteves, "The quest for equity in Latin America: a comparative analysis of the health care reforms in Brazil and Colombia," Int. J. Equity Health, vol. 11, pp. 1–6, 2012.	English	Equity in the health system reforms in Colombia and Brazil	Brazil, Colombia	Yes	Cross country comparison/Case Study	equity, efficiency, social participation, decentralization, integrality, accessibility, privatization, targeting	Y
124	A. C. G. do E. Santo, V. C. N. Fernando, and A. F. B. Bezerra, "Despesa pública municipal com saúde em Pernambuco, Brasil, de 2000 a 2007 Municipal," Cienc. Saude ColetivaSaúde, vol. 17, no. 4, pp. 861–871, 2012.	Portuguese	Municipal public health spending in Pernambuco Brazil	Brazil	Yes	Cross-sectional	equality	N
125	F. Tobar, I. Drake, and E. Martich, "Alternativas para la dopcion de politicas centradas en el acceso a medicamentos," Rev Panam Salud Publica, vol. 32, no. 6, pp. 457–463, 2012.	Spanish	Policies of drug access in Latin America	Latin America	No	Situation analysis	efficiency, sustainability, accessibility, affordability, privatization, market, competitiveness, enforcement of enforcement of regulation	Y
126	M. C. Pedroso and A. M. Malik, "Cadeia de valor da saúde: um modelo para o sistema de saúde brasileiro Healthcare," Cien. Saude Colet., vol. 17, no. 10, pp. 2757–2772, 2012.	Portuguese	A model of health care management for Brazil	Brazil	No	Framework	management	N
127	C. W. Keck and G. A. Reed, "The curious case of Cuba," Am. J. Public Health, vol. 102, no. 8, pp. e13-22, 2012.	English	Health system of Cuba	Cuba	No	Discussion paper	universality, efficiency, equality, decentralization, prevention, integration, effectiveness	Y
128	A. Stamford and M. Cavalcanti, "Legal decisions on access to medicines in Pernambuco, Northeastern Brazil," Rev. Saude Publica, vol. 46, no. 5, pp. 791–799, 2012.	English	Legal decision on access to medicines in Brazil	Brazil	Yes	Cross-sectional Mixed methods	universality, accessibility, comprehensiveness, free-access	N
129	A. Zúñiga Fajuri, "Un modelo de adjudicación de recursos sanitarios para Chile," Acta Bioeth., vol. 18, no. 2, pp. 221–230, 2012.	Spanish	A model of health resource allocation in Chile	Brazil	No	Stakeholder input	universality, solidarity, social justice, equity, efficiency, equality, rationing	N

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130	A. Uthoff, J. Miguel Sánchez, and R. Campusano, “The health insurance market: lessons on the conflict between equivalence and solidarity,” Cepal Rev., vol. 0, no. 108, pp. 141–159, 2012.	English	Equity, solidarity and equivalence in health system reform in Chile	Brazil	No	Situation analysis	universality, solidarity, equity, efficiency, accessibility,	N
131	J.-P. Alfred, “QUEL EST LE COÛT RÉEL DE LA COUVERTURE UNIVERSELLE EN SANTÉ EN HAÏTI ?,” Sante Publique (Paris)., vol. 24, no. 5, pp. 453–458, 2012.	French	Costs of Universal health coverage in Haiti	Haiti	No	Situation analysis	universality	N
132	B. Cabieses and M. Espinoza, “Redistributing health through public health policies in Latin America: fair to whom and fair how?,” Rev. Panam. Salud Publica, vol. 32, no. 5, pp. 387–388, 2012.	English	Fairness and redistributing of care in LA	Latin America	No	Commentary	social justice, equity, prevention	N
133	V. J. Wirtz, Y. Santa-Ana-Tellez, E. Servan-Mori, and L. Avila-Burgos, “Heterogeneous effects of health insurance on out-of-pocket expenditure on medicines in Mexico,” Value Heal., vol. 15, no. 5, pp. 593–603, 2012.	English	Effects of health insurance on out-of-pocket expenditure on medicines in Mexico	Mexico	Yes	Cross-sectional	equity, sustainability, accessibility, timely access, financial-protection	N
134	F. S. Vieira and P. Zucchi, “Financing of Pharmaceutical Services in Brazilian Public Health System,” Saude E Soc., vol. 22, no. 1, pp. 73–84, 2013.	English		Brazil	Yes	Cross-sectional	efficiency, sustainability, decentralization, availability, rationality	N
135	G. Paraje and F. Vásquez, “Health equity in an unequal country: the use of medical services in Chile.,” Int. J. Equity Health, vol. 11, no. 81, pp. 1–16, 2012.	English	Health equity in Chile	Chile	Yes	Cross-sectional	equality, equity, accessibility, solidarity, privatization	Y
136	A. Honda, “10 best resources on ... pay for performance in low- and middle-income countries,” Health Policy Plan., vol. 28, no. 5, pp. 454–457, 2013.	English	Pay-for-performance in LMICs	Latin America	No	Literature review	efficiency, quality, MDG	N
137	R. Bitran, “Explicit Health Guarantees for Chileans: The AUGE Benefits Package,” International Bank for Reconstruction and Development, Washington DC, 2013.	English	Social health insurance and universal coverage in Chile	Chile	No	Discussion paper	universality, equity, efficiency, sustainability, financial-protection, fiscal-sustainability	N
138	Grupo de Estudios de ética clínica de la sociedad médica de Santiago, “Dimensión ética en la organización de la atención de salud.,” Rev Med Chile, vol. 141, no. 6, pp. 780–786, 2013.	Spanish	Ethics in the management of health system	Chile	No	Discussion paper	social justice, efficiency, equality, sustainability, quality	N
139	M. Flynn, “Brazilian pharmaceutical diplomacy: social democratic principles versus soft power interests,” Int. J. Heal. Serv., vol. 43, no. 1, pp. 67–89, 2013.	English	Pharmaceutical international policy of Brazil	Brazil	No	Discussion paper	universality, solidarity, sustainability, accessibility, right	Y
140	F. Sánchez-Moreno, “La inequidad en salud afecta el desarrollo en el Perú,” Rev Peru Med Exp Salud Publica, vol. 30, no. 4, pp. 676–682, 2013.	Spanish	Equity in health in Peru	Peru	No	Discussion paper	universality, equity, gradualness, effectiveness, progressiveness	N
141	D. McIntyre, M. K. Ranson, B. K. Aulakh, and A. Honda, “Promoting universal financial protection: evidence from seven low- and middle-income countries on factors facilitating or hindering progress,” Heal. Res. Policy Syst., vol. 11, pp. 1–10, 2013.	English	Universal financial protection in health in LMICs	Costa Rica	Yes	Case study	universality, accessibility, financial-protection, universal-financial-protection	N
142	I. Rico-Alba and A. Figueras, “The fuzzy line between needs, coverage, and excess in the Mexican Formulary List: an example	English	Coverage of health services in Mexico	Mexico	Yes	Cross-sectional	rationality, market, efficacy, safety	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
	of qualitative market width analysis,” Eur J Clin Pharmacol, vol. 69, no. 4, pp. 949–956, 2013.							
143	L. Morgan et al., “Financial incentives and maternal health: where do we go from here?,” J Heal. Popul Nutr, vol. 31, no. 4, pp. S8-22, 2013.	English	Financial incentives and maternal health in LMICs	Latin America	No	Literature review	sustainability, accountability, evidence, quality, utilization, cost-effectiveness	N
144	A. Zúñiga F, “Isapres, tribunal constitucional y distribución del derecho a cuidado sanitario,” Rev Med Chile, vol. 141, no. 4, pp. 514–518, 2013.	Spanish	Constitution right to health and health insurance in Chile	Chile	No	Situation analysis	universality, equity, efficiency, equality, decentralization, accessibility, timely access, right, quality, financing-coverage, sufficiency	Y
145	A. Glassman et al., “Impact of conditional cash transfers on maternal and newborn health,” J Heal. Popul Nutr, vol. 31, no. 4, pp. S48-66, 2013.	English	Conditional Cash transfer, MDG and maternal health in LMICs	Latin America	Yes	Quantitative systematic review	utilization, MDG	Y
146	S. Franco, “Entre los negocios y los derechos,” Rev Cub Salud Publica, vol. 39, no. 2, pp. 268–284, 2013.	Spanish	Ethic and private health insurance in Colombia	Colombia	No	Discussion paper	sustainability, market, right to health	N
147	M. Gragnolati, M. Lindelow, and B. Couttolenc, Twenty years of health system reform in Brazil: an assessment of the sistema unico de saude. Washington DC: World Bank, 2013.	English	Health system reform in Brazil	Brazil	No	Situation analysis	equity, efficiency, decentralization, accessibility, financial-protection, quality, accountability	Y
148	L. Reveiz et al., “Litigios por derecho a la salud en tres países de América Latina: revisión sistemática de la literatura,” Rev. Panam. Salud Publica, vol. 33, no. 3, pp. 213–222, 2013.	Spanish	Right to health litigation in Brazil, Colombia and Costa Rica	Costa Rica, Brazil. Colombia	Yes	Qualitative systematic review	accessibility, right to health, effectiveness	N
149	S. Leatherman, K. Geissler, B. Gray, and M. Gash, “Health financing: A new role for microfinance institutions?” 2013.	English	Health financing by microfinance institutions in four poor countries	Bolivia	Yes	Cross-sectional	financial-stability, affordability	N
150	R. M. Burke et al., “The burden of pediatric diarrhea: a cross-sectional study of incurred costs and perceptions of cost among Bolivian families,” BMC Public Health, vol. 13, no. 708, pp. 1–10, 2013.	English	Costs of pediatric diarrhea in Bolivia	Bolivia	Yes	Cross-sectional	financial-protection	N
151	N. Beyeler, A. York De La Cruz, and D. Montagu, “The impact of clinical social franchising on health services in low- and middle-income countries: a systematic review,” PLoS One, vol. 8, no. 4, p. e60669, 2013.	English	Clinical social franchising in LMICs	Latin America	Yes	Qualitative systematic review	equity, accessibility, quality, cost-effectiveness, utilization	N
152	J. Campbell et al., “Human resources for health and universal health coverage: fostering equity and effective coverage,” Bull World Heal. Organ, vol. 91, no. 11, pp. 853–863, 2013.	English	Equity, universal coverage and human resources	Mexico, Brazil	Yes	Case study	universality, social justice, equity, efficiency, sustainability, transparency, availability, acceptability, accessibility, quality, effectiveness, financial-protection, utilization, accountability	Y
153	M. K. Kim, R. J. Blendon, and J. M. Benson, “What is driving people’s dissatisfaction with their own health care in 17 Latin	English	Dissatisfaction with health care in LA	Latin America	Yes	Cross-sectional	universality, integrality, accountability, quality	Y

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
	American countries?" Heal. Expect., vol. 16, no. 2, pp. 155–163, 2013.							
154	V. C. Bachelet, "Hospital concessions in Chile: where we are and where we are heading," Medwave, vol. 14, no. 10, p. e6039, 2014.	Spanish	Hospitals concessions and private financing in Chile	Chile	No	Stakeholder position paper	market, privatization	Y
155	A. Mendes, "The public fund and the constraints of Brazilian universal health financing," Saude E Soc., vol. 23, no. 4, pp. 1183–1197, 2014.	English	Universal health financing in Brazil	Brazil	No	Discussion paper	universality, private financing, public financing	N
156	M. Juan, "Hacia un Sistema Nacional de Salud Universal," Cir Cir, vol. 82, no. 1, pp. 98–108, 2014.	Spanish	Universal health system in Mexico	Mexico	No	Government position paper	efficiency, timely access, quality, right to health, sufficiency, accountability	N
157	C. V. Machado, L. D. de Lima, and C. L. T. de Andrade, "Federal funding of health policy in Brazil: trends and challenges," Cad Saúde Publica, vol. 30, no. 1, pp. 187–200, 2014.	English	Federal funding of health in Brazil	Brazil	Yes	Interrupted time series	universality, decentralization	N
158	A. Vargas-Bustamante and C. A. Méndez, "Health care privatization in Latin America: comparing divergent privatization approaches in Chile, Colombia, and Mexico.," J. Health Polit. Policy Law, vol. 39, no. 4, pp. 841–86, Aug. 2014.	English	Health care privatization in LA	Mexico, Chile, Colombia	Yes	Comparative policy analysis	universality, decentralization, privatization, market	N
159	B. Cabieses and P. Bird, "Glossary of access to health care and related concepts for low- and middle-income countries (LMICs): a critical review of international literature," Int. J. Heal. Serv., vol. 44, no. 4, pp. 845–861, 2014.	English	Access to health care in LMICs	Latin America	Yes	Quantitative systematic review	universality, equity, equality, availability, acceptability, accessibility, right to health, affordability, utilization	N
160	M. A. Espinoza and B. Cabieses, "Equidad en salud y evaluacion de tecnologias sanitarias en Chile," Rev Med Chile, vol. 142, no. S1, pp. S45-49, 2014.	Spanish	Equity and health technology assessment in Chile	Chile	No	Discussion paper	equity, efficacy, effectiveness, cost-effectiveness	Y
161	C. Flood and A. Gross, "Litigating the right to health: what can we learn from a comparative law and health care systems approach.," Heal. Hum. Rights, vol. 16, no. 2, pp. 62–72, 2014.	English	Litigating the right to health	Colombia, Brazil	Yes	Comparative policy analysis	equity, equality, right to health	N
162	J. D. Ament et al., "Health impact and economic analysis of NGO-supported neurosurgery in Bolivia," J Neurosurg Spine, vol. 20, no. 4, pp. 436–442, 2014.	English	Health impact and economic analysis of NGO-supported neurosurgery in Bolivia	Bolivia	Yes	Cost-effectiveness study	solidarity, international-solidarity, cost-effectiveness	N
163	R. M. Burke et al., "The economic burden of pediatric gastroenteritis to Bolivian families: a cross-sectional study of correlates of catastrophic cost and overall cost burden," BMC Public Health, vol. 14, no. 642, pp. 1–12, 2014.	English	Catastrophic costs of pediatric gastroenteritis in Bolivia	Bolivia	Yes	Cross-sectional	financial-protection	N
164	K. D. Rao, V. Petrosyan, E. C. Araujo, and D. McIntyre, "Progress towards universal health coverage in BRICS: translating economic growth into better health," Bull. World Health Organ., vol. 92, no. 6, pp. 429–435, 2014.	English	Universal health coverage in BRICS	Brazil	No	Situation analysis	universality, equity, financial-protection, right to health	N
165	I. Garcia-Subirats et al., "Barriers in access to healthcare in countries with different health systems. A cross-sectional study in	English	Access to health care in Brazil and Colombia	Brazil, Colombia	Yes	Cross-sectional	equity, efficiency, decentralization, accessibility, market, privatization	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
	municipalities of central Colombia and north-eastern Brazil," Soc. Sci. Med., vol. 106, pp. 204–213, 2014.							
166	P. Rizo-Rios, A. G. Rivera, I. R. Oropeza, and O. C. Ramirez, "The Update of the Mexican Health Care Formulary and Supply Catalog in the Context of the Health Technology Assessment," Value Heal. Reg. Issues, vol. 5, no. C, pp. 29–34, 2014.	English	Health benefits plan and health technology assessment in Mexico	Mexico	No	Government policy	efficiency, availability, effectiveness, efficacy, optimization, quality	Y
167	D. Class, E. Cavagnero, K. Ferl, and S. Rajkumar, "Costa Rica - Health financing profile," International Bank for Reconstruction and Development, Washington DC, 2014.	English	Health financing profile of Costa Rica	Costa Rica	No	Jurisdictional review	universality, equity, sustainability	N
168	P. A. Mosquera et al., "Challenges of implementing a primary health care strategy in a context of a market-oriented health care system: the experience of Bogota, Colombia," Int J Heal. Plann Mgmt, vol. 29, no. 4, pp. e347–e367, 2014.	English	Primary health care strategy in a context of a market-oriented system in Colombia	Colombia	Yes	Case study	efficiency, decentralization, market, primary-care	Y
169	G. Bloom, S. Henson, and D. H. Peters, "Innovation in enforcement of regulation of rapidly changing health markets," Global. Health, vol. 10, no. 53, pp. 1–11, 2014.	English	Innovation in health markets in LMICs	Latin America	No	Literature review	availability, enforcement of enforcement of regulation, accountability, effectiveness, cost-effectiveness	N
170	P. Frenz, I. Delgado, J. S. Kaufman, and S. Harper, "Achieving effective universal health coverage with equity: evidence from Chile," Health Policy Plan., vol. 29, no. 6, pp. 717–731, 2014.	English	Universal health coverage and equity in Chile	Chile	Yes	Cross-sectional	universality, solidarity, equity, effectiveness	Y
171	J. Frenk, "Leading the way towards universal health coverage: A call to action," Lancet, vol. 385, no. 9975, pp. 1352–1358, 2015.	English	Universal health coverage and health system financing	Latin America	No	Discussion paper	universality, solidarity, equity, efficiency, social participation, transparency, right to health, effectiveness, quality, accountability, financial-protection	Y
172	M. A. Clark, "The Meanings of Universal Health Care in Latin America.," J. Heal. Polit. Policy Law, vol. 40, no. 1, pp. 221–226, 2015.	English	The meanings of universal health care in Latin America	Costa Rica, Chile	No	Discussion paper	universality	Y
173	A. C. Laurell, "The Mexican Popular Health Insurance: Myths and Realities," Int. J. Heal. Serv., vol. 45, no. 1, pp. 105–125, 2015.	English	Universal insurance coverage and health system reform in Mexico	Mexico	No	Discussion paper	universality, equity, sustainability, decentralization, financial-protection, quality, efficacy, private	N
174	D. Titelman, O. Cetrángolo, and O. L. Acosta, "Universal health coverage in Latin American countries: how to improve solidarity-based schemes.," Lancet, vol. 385, no. 9975, pp. 1359–1363, 2015.	English	Solidarity and universal health coverage in LA	Latin America	No	Discussion paper	universality, solidarity, equity, financial-protection	N
175	M. Bachelet, "Towards universal health coverage: applying a gender lens.," Lancet, vol. 385, no. 9975, pp. e25-6, 2015.	English	Gender and universal health coverage in Chile	Chile	No	Commentary	cost-effective, gender-equity	Y
176	A. Castro, V. Savage, and H. Kaufman, "Assessing equitable care for Indigenous and Afrodescendant women in Latin America," Rev Panam Salud Publica, vol. 38, no. 2, pp. 96–109, 2015.	English	Equity, gender, indigenous and health coverage in Latin America	Latin America	Yes	Qualitative Systematic review	equity, interculturality, indigeneity, afro descendant-equity, gender-equity	Y

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
177	P. E. Ekmekci and B. Arda, "Enhancing John Rawls's Theory of Justice to Cover Health and Social Determinants of Health.," Acta Bioeth., vol. 21, no. 2, pp. 227–236, 2015.	English	Rawlsian justice	Latin America	No	Discussion paper	justice, equity	Y
178	A. E. Yamin and A. Frisancho, "Human-rights-based approaches to health in Latin America.," Lancet, vol. 385, no. 9975, pp. e26-9, 2015.	English	Human rights and health in LA	Latin America	No	Commentary	universality, equity, equality, social participation, transparency, right to health, accountability	N
179	J. Vega and P. Frenz, "Latin America: Priorities for universal health coverage," The Lancet, vol. 385, no. 9975. pp. e31-32, 2015.	English	Universal health coverage in LA	Latin America	No	Commentary	universality, equity, efficiency, transparency, availability, acceptability, accessibility, prioritization, effectiveness, quality	Y
180	F. Pega, S. Y. Liu, S. Walter, and S. K. Lhachimi, "Unconditional cash transfers for assistance in humanitarian disasters: effect on use of health services and health outcomes in low- and middle-income countries," Cochrane Database Syst. Rev., no. 9, p. 62, 2015.	English	Unconditional cash transfer for humanitarian crisis in LMICs	Latin America	Yes	Quantitative systematic review	effectiveness, evidence-based	N
181	R. Atun et al., "Health-system reform and universal health coverage in Latin America.," Lancet, vol. 385, no. 9974, pp. 1230–1247, 2015.	English	Universal health coverage and health system reforms in Latin America	Costa Rica, Cuba, Mexico, Argentina, Brazil, Chile, Colombia, Peru, Uruguay, Venezuela	No	Framework	universality, solidarity, equity, efficiency, sustainability, decentralization, right, south-south-cooperation, financial-protection	Y
182	J. C. Kohler, N. Mitsakakis, F. Saadat, D. Byng, and M. G. Martinez, "Does Pharmaceutical Pricing Transparency Matter? Examining Brazil's Public Procurement System," Global. Health, vol. 11, pp. 1–13, 2015.	English	Pharmaceutical pricing in Brazil	Brazil	Yes	Cross-sectional	equity, efficiency, social participation, transparency, accessibility, effectiveness, accountability, responsiveness, inclusiveness	Y
183	D. Razzouk et al., "The impact of antipsychotic polytherapy costs in the public health care in Sao Paulo, Brazil," PLoS One, vol. 10, no. 4, p. e0124791, 2015.	English	Costs of antipsychotic to the public health system in Brazil	Brazil	Yes	Cross-sectional	cost-effectiveness, evidence-based	N
184	M. C. Restrepo-Méndez et al., "Progress in reducing inequalities in reproductive, maternal, newborn, and child health in Latin America and the Caribbean: an unfinished agenda.," Rev. Panam. Salud Publica, vol. 38, no. 1, pp. 9–16, 2015.	English	Inequalities in maternal health in LA	Latin America	Yes	Cross-sectional	equity, MDG	N
185	S. Leatherman and K. H. Geissler, "Providing primary health care through integrated microfinance and health services in Latin America.," Soc. Sci. Med., vol. 132, pp. 30–37, 2015.	English	Primary health care and micro-finance in LA	Mexico, Nicaragua, Argentina, Bolivia, Peru	Yes	Case study	availability, acceptability, accessibility, affordability	N
186	V. Tangcharoensathien, A. Mills, and T. Palu, "Accelerating health equity: The key role of universal health coverage in the Sustainable Development Goals," BMC Med., vol. 13, no. 101, pp. 1–5, 2015.	English	Universal health coverage, equity, MDG, SDG	Latin America	No	Discussion paper	universality, equity, sustainability, accessibility, MDG, primary-healthcare, financial-protection	Y

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
187	D. Cotlear et al., "Overcoming social segregation in health care in Latin America.," Lancet, vol. 385, no. 9974, pp. 1248–1259, 2015.	English	Segregation and health care in Latin America	Latin America	No	Situation analysis	universality, free choice, decentralization, targeting, unification, right	Y
188	J. Grogger, T. Arnold, A. S. León, and A. Ome, "Heterogeneity in the effect of public health insurance on catastrophic out-of-pocket health expenditures: the case of Mexico," Health Policy Plan., vol. 30, no. 5, pp. 593–599, 2015.	English	Public health insurance on catastrophic out-of-pocket health expenditures in Mexico	Mexico	Yes	Cross-sectional	financial-protection	N
189	A. Arredondo, E. Orozco, and R. Aviles, "Evidence on equity, governance and financing after health care reform: lessons for Latin American countries," Saude E Soc., vol. 24, no. Supl 1, pp. 162–175, 2015.	English	Equity, governance and financing health system reform in Mexico	Mexico	Yes	Cross-sectional	equity, social participation, accountability, governance, financial-protection, targeting	Y
190	L. O. M. de Andrade et al., "Social determinants of health, universal health coverage, and sustainable development: case studies from Latin American countries.," Lancet, vol. 385, no. 9975, pp. 1343–1351, 2015.	English	Universal health coverage in LA	Cuba, Brazil, Chile, Colombia	Yes	Case study	universality, equity, social participation, intersectorality	N
191	A. Thoumi, K. Udayakumar, E. Drobnick, A. Taylor, and M. McClellan, "Innovations In Diabetes Care Around the World: Case Studies Of Care Transformation Through Accountable Care Reforms," Health Aff., vol. 34, no. 9, pp. 1489–1497, 2015.	English	Accountable health reforms and diabetes care in Mexico, USA and India	Mexico	Yes	Case study	accountability	N
192	N. Heredia, A. C. Laurell, O. Feo, J. Noronha, R. González-Guzmán, and M. Torres-Tovar, "The right to health: what model for Latin America?," Lancet, vol. 385, no. 9975, pp. e34-7, 2015.	English	the right to health and universal health coverage in LA	Latin America	No	Commentary	universality, right to health	N
193	R. B. Saltman, "Health sector solidarity: A core European value but with broadly varying content," Isr. J. Health Policy Res., vol. 4, no. 1, pp. 1–7, 2015.	English	Solidarity in Europe	NA	No	Discussion paper	solidarity	Y
194	C. E. Abadia-Barrero, "Neoliberal Justice and the Transformation of the Moral: The Privatization of the Right to Health Care in Colombia,"	English	The privatization of the right to health in Colombia	Colombia	Yes	Ethnographic study	Right to health, market, deservedness, justice	N
195	J. Mulligan, "Insurance Accounts: The Cultural Logics of Health Care Financing," Med. Anthropol. Q., vol. 30, no. 1, pp. 37–61, 2016.	English	Insurance and health care financing Puerto Rico	Latin America	Yes	Ethnographic study	market, targeting, privatization	N
196	C. Hartmann, "Postneoliberal Public Health Care Reforms: Neoliberalism, Social Medicine, and Persistent Health Inequalities in Latin America.," Am. J. Public Health, vol. 106, no. 12, pp. 2145–2151, 2016.	English	Health inequalities and public health care reforms in Latin America	Bolivia, Ecuador, Venezuela	No	Discussion paper	solidarity, efficiency, equality, free choice, decentralization, intersectorality, interculturality, protection of indigenous people, market, privatization, profit, cost-benefit, indigeneity	Y
197	C. M. Domingos, E. de F. de Almeida Nunes, B. G. Carvalho, and F. de F. Mendonça, "A legislação da atenção básica do Sistema Único de Saúde: uma análise documental," Cad. Saude Publica, vol. 32, no. 3, p. e00181314, 2016.	Portuguese	Legislation in primary care in Brazil	Brazil	Yes	Documentary analysis	equity, social participation, integrality, accessibility	N

#	Reference	Language	Focus of the article	Countries	Primary research ?	Type of paper	Values identified	Purposively sampled
198	A. A. Portella and R. P. Teixeira, “Federalismo fiscal e efetividade da dignidade da pessoa humana: análise da posição do município na estrutura do financiamento público brasileiro e a escassez de recursos para as ações de saúde,” Rev. Direito Da Cid., vol. 8, no. 2, pp. 631–679, 2016.	Portuguese	Fiscal federalism, human dignity and financing of health system in Brazil	Brazil	No	Situation analysis	sustainability, right to health	N
199	H. Waitzkin and I. Hellander, “The History and Future of Neoliberal Health Reform: Obamacare and its predecessors,” Int. J. Heal. Serv., vol. 46, no. 4, pp. 747–766, 2016.	English	Affordable care act, health reforms in LA	Latin America	No	Discussion paper	market, right to health	N
200	M. Á. González-Block, A. Figueroa, I. García-Téllez, and J. Alarcón, “Asignación financiera en el Sistema de Protección Social en Salud de México: retos para la compra estratégica,” Salud Publica Mex., vol. 58, no. 5, pp. 522–532, 2016.	Spanish	Finance allocation in the Mexican health system	Mexico	Yes	Cross-sectional	universality, financial-protection, efficacy	N
201	K. G. Martinelli, E. T. dos Santos Neto, S. G. Nogueira da Gama, and A. E. Oliveira, “Access to prenatal care: inequalities in a region with high maternal mortality in southeastern Brazil,” Cien. Saude Colet., vol. 21, no. 5, pp. 1647–1657, 2016.	English	Access to prenatal care and inequalities in Brazil	Brazil	Yes	Cross-sectional	equity, availability, acceptability, accessibility	Y
202	M. R. Reich et al., “Moving towards universal health coverage: lessons from 11 country studies,” Lancet, vol. 387, no. 10020, pp. 811–816, 2016.	English	Universal health coverage and health system financing	Brazil, Peru	No	Situation analysis	universality	N
203	M. Matus-López, L. Prieto Toledo, and C. C. Pedraza, “Evaluació del espacio fiscal para la salud en Perú,” Rev Panam Salud Publica, vol. 40, no. 1, pp. 64–69, 2016.	Spanish	Fiscal opportunities to financing health in Peru	Peru	Yes	Cross-sectional	sustainability, accessibility	N
204	L. Avila-Burgos, L. Cahuan-Hurtado, J. Montañez-Hernández, E. Servan-Mori, B. Aracena-Genao, and A. del Río-Zolezzi, “Financing Maternal Health and Family Planning: Are We on the Right Track? Evidence from the Reproductive Health Subaccounts in Mexico, 2003-2012,” PLoS One, vol. 11, no. 1, p. e0147923, 2016.	English	Financing maternal health in Mexico	Mexico	Yes	Cohort study	efficiency, accessibility, financial-protection, accountability, MDG	Y
205	B. Hanson, KaraMcPake, “Managing the public-private mix to achieve universal health coverage,” Lancet, vol. 388, no. 10044, pp. 622–630, 2016.	English	Public-private mix and universal health coverage	Latin America	No	Literature review	universality	N
206	F. N. Alvarez, M. Leys, H. E. Rivera Mérida, and G. Escalante Guzmán, “Primary health care research in Bolivia: systematic review and analysis,” Health Policy Plan., vol. 31, no. 1, pp. 114–128, 2016.	English	Primary health care in Bolivia	Bolivia	Yes	Quantitative systematic review	universality, intersectorality, integrality, interculturality, primary-healthcare, efficacy, accountability	N
207	Defensoría del Pueblo, “Informe tutela y acceso a información-2016,” Bogotá, 2017.	Spanish	‘Tutela” in Colombia	Colombia	No	Situation analysis	right to health	Y

Appendix 5. Values identified in papers reviewed

Value	Number of papers addressing	Value	Number of papers addressing	Value	Number of papers addressing
Equity	95	Integration	5	Financial autonomy	1
Universality	74	Interculturality	5	Financial soundness	1
Efficiency	72	Intersectorality	5	Financial stability	1
Accessibility	61	Pluralism	4	Flexibility	1
Decentralization	46	Public financing	4	Free access	1
Quality	38	Redistribution	4	Gradualness	1
Financial protection	35	Sufficiency	4	Implementability	1
Right	29	Country solidarity	3	Inclusiveness	1
Sustainability	28	Cultural appropriatenes s	3	Individuality	1
Social participation	27	Demand subsidies	3	Justice	1
Solidarity	27	Institutional autonomy	3	Mobility	1
Privatization	25	Management	3	Multiculturalism	1
Accountability	24	Planning	3	Optimization	1
Effectiveness	24	Prioritization	3	Portability	1
Market	21	Profitability	3	Progressiveness	1
Equality	18	User satisfaction	3	Proportionality	1
Availability	15	Adjust	2	Protection vulnerable population	1
Targeting	15	Cost containment	2	Public participation	1
Efficacy	13	Democratizatio n	2	Rationality	1
Millennium Development Goals (MDG)	13	Governance	2	Reasonableness	1

Value	Number of papers addressing	Value	Number of papers addressing	Value	Number of papers addressing
Affordability	12	Hierarchization	2	Reciprocity	1
Cost effectiveness	12	Professional autonomy	2	Regressiveness	1
Free choice	12	Responsiveness	2	Relevance	1
Primary healthcare (PHC)	12	Sovereignty	2	Safety	1
Rationing	12	Adequate use	1	Savings	1
Competitiveness	11	Afro descendent equity	1	Self financing	1
Social justice	11	Austerity	1	Self management	1
Utilization	11	Centralization	1	Separation of functions	1
Acceptability	10	Citizenship	1	Simplicity	1
Coverage	10	Community participation	1	Social cohesion	1
Transparency	10	Comprehensiveness	1	South-South cooperation	1
Integrality	9	Compulsoriness	1	Stewardship	1
Gender equity	7	Continuity	1	Suitability	1
Indigeneity	6	Cost benefit	1	Transferability	1
Prevention	6	Cost efficiency	1	Transparent procurement	1
Stewardship	6	Cultural autonomy	1	Trust	1
Timely access	6	Deservedness	1	Unification	1
Evidence based	5	Empowerment	1	Voluntariness	1
Fairness	5	Feasibility	1		

Chapter 3. Preface

This chapter moves away from the broader conceptual understanding of the roles of values in Latin American health systems presented in chapter 2 and focuses on policy decision-making about health system financing in Chile and Colombia through a multiple-case embedded design study. Kingdon's agenda setting and 3I+E frameworks, and the theoretical framework developed in chapter 2, are used to analyze two decisions in each country. The chapter addresses an important gap in our understanding about how declared values are used to inform health policy decisions.

In Chile, the first embedded decision was the AUGE/GES plan, which is a universal care plan designed to make medical coverage available to all Chilean citizens suffering from one or more diseases on a list of covered diseases. The second embedded decision was the decision to pass a law mandating the universal coverage of high cost diseases (known in Chile as the Ricarte Soto Law) which provides financial protection for treatments associated with specific high-cost diseases to all citizens regardless of health system affiliation or socioeconomic status.

In Colombia, the first embedded decision was the declaration of health as a fundamental right, which implies a change in the notion of health as a public service (first with the rule T-760 and later with the Statutory Law). For the second decision, I selected the mechanism established by the Health Ministry to explicitly exclude technologies that cannot be funded within the available resources of the publicly financed health system.

I was responsible for the study design, variable selection and definition, and data analysis. Data analysis was completed in early 2017. I drafted the manuscript and as co-authors, all thesis committee members provided feedback on several drafts, which were incorporated into the manuscript.

Aspect	Study 1 (chapter 2)	Study 2 (chapter 3)	Study 3 (chapter 4)
Questions addressed	7) What values inform decisions about health system financing? 8) How do values inform these decisions? 9) Under what conditions values are influential?	7) What socially and politically declared values are important in making decisions about health-system financing? 8) How do values inform these decisions? 9) Under what conditions were values influential?	7) What declared and undeclared values are important in the decision-making processes about health-system financing? 8) How do values inform these decisions? 9) Why are some values incorporated in these processes?
Design	• Critical interpretive synthesis	– Multiple case embedded-design – Discourse analysis	– Multiple case embedded-design – In-depth semi-structured interviews
Scope	• Health-system financing in Latin America	• Two health-system financing policy decisions in each of Chile and Colombia	• Two health-system financing policy decisions in each of Chile and Colombia
Data source(s)	• Scholarly literature	• Policy documents and media	• Views and experiences of policymakers and stakeholders
Type of values studied	• Declared values	• Declared values	• Declared and undeclared values
Connections between studies	• Developed a framework used as an analytical tool in studies 2 and 3	• Analyzed data using the framework developed in study 1 • Identified and explained the role of declared values to inform analysis in study 3	• Analyzed data using the framework developed in study 1 • Complemented findings from study 2 about declared values with findings about undeclared values • Identified reasons for why declared values identified in study 2 were used
Substantive contributions	• Provides a new theoretical framework of how and under what conditions values influence the policy process on for health	• Provides the first analysis of how declared values have informed two health-system financing decisions in each of Chile and Colombia	• Enriches the discourse analysis presented in study 2 to provide first-hand insights from policymakers and stakeholders about which declared and undeclared values were prioritized in

	system-financing decisions in Latin America		the policy decisions and how and why they were used
Methodological contributions	• Presents an approach for the development of a theoretical framework through a critical interpretive synthesis in a nascent area of study, where the available literature is sparse and methodologically diverse	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, and provides explanation of what values influenced those decisions, as well as how they were influential •	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, enriches the findings of study 2 by identifying undeclared values and interpretations of how values influence the four decisions, and provides the opportunity to explore why some values are incorporated in these policy processes
Theoretical contributions	• Identifies four categories of social and political values playing different roles in the policy development process about health system financing in Latin America, and four conditions under which values influence decision-making in this area	• Identifies what declared values influenced two policy decisions about health-system financing in Chile and Colombia and how those values played a role • Proposes that values entrenched through large structural reforms are central to shaping the many incremental changes made to health systems in subsequent years or decades	• Provides explanations of how and why some values influenced the four decisions, and proposes that policymakers only consider a small set of prioritized and often competing values to simplify the complex interplay of values influencing a particular decision

Understanding the role of values in the health policy decision-making process about health-system financing in Chile and Colombia: A discourse analysis

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Abstract

Background. All health policy decisions are value-laden, but health-system financing decisions typically need to balance even more competing values than decisions about governance or delivery arrangements given the different role of public and private finance and the different values driving those approaches to financing systems. Among all the Latin American countries that have introduced private health insurance, Chile and Colombia have not only been pioneers in this area,

but they are also the countries that have implementated of these policies the most comprehensively. This comparative context offers a unique opportunity to assess what values play a role in policy decision-making about health system financing and how policymakers use values to inform the decision-making process.

Methods. An embedded multiple-case study design was used in Chile and Colombia for two specific decisions in each country, one structural decision within 10 years of when data was collected, and another narrower policy decision implemented within two years of data collection. I conducted a discourse analysis using policy documents and media coverage addressing the four decisions chosen. Analysis involved a constant comparative approach and thematic analysis for each case study, incorporating framework analysis (Kingdon, 3I+E, and our framework developed in chapter 2) to generate descriptive and explanatory themes from data.

Results. A total of 376 documents were reviewed, and from this 113 were purposively sampled for the analysis. I found that in Chile and Colombia, the development and implementation of policies protecting the right to health brought a discussion about what should be included or excluded from this protection onto each government's agenda. When the four embedded decisions were considered in the political context of each country, I identified that values entrenched through large structural reforms are key to shaping the many incremental changes made to health systems in subsequent years or decades. And therefore, these large structural reforms serve as inflection points in policy development as they determine the values that shape the health system over time.

Conclusion. The study of values in the policy decision-making process in Latin America is an emerging field. This effort to analyze health-system financing policies in Chile and Colombia using analytical frameworks related to government agenda setting, policy development and implementation and by considering the influence of societal values is a unique contribution to the

body of knowledge in this field. As such, it is an opportunity to open further exploration of the role of values in different health decisions, political sectors besides health, and even other jurisdictions.

Introduction

Recently, there has been much interest in the role of values (e.g., individual preferences and morals and/or guiding principles of health-system organizations) in shaping policy decisions about health systems.(1–3) While all health policy decisions are value-laden,(4) health-system financing decisions typically need to balance even more competing values than decisions about governance or delivery arrangements.

In decision-making processes about health-system financing, values such as efficiency, equity, quality, sustainability, and universality are often embedded in all stages of the policy process, ranging from the prioritization of some issues over others on a government's agendas, and the development of policy options to address an issue, to the implementation of selected policy options and their monitoring and evaluation.(4) However, it is often not clear how such values are incorporated into policy decision-making. Moreover, understanding the role of values is complex given the wide range of values prioritized by different stakeholders and the many ways in which values can drive policy decisions.(5)

Latin America offers a rich context for the study of the role of values in policy decision-making about health-system financing. At the end of the 1980s and 90s, virtually all countries in Latin America began the process of reforming their health systems according to the ideas promoted by the World Bank (WB) and the Inter-American Development Bank (IDB).(6–12) As a consequence, most of these countries introduced private insurance in their health systems (which were the dominant values espoused by the WB and IDB), particularly Argentina, Brazil, Chile, Colombia, Mexico and Uruguay, which already featured a stronger presence of private health insurance.(13) Despite the relevance of studying how values have informed policy decision-making about health-system financing in low and middle-income countries, such as those in Latin

America where private insurance companies are actively seeking to maximize profits, this subject has not received much research attention.(14–16)

Among all the Latin American countries that have introduced private health insurance, Chile and Colombia have not only been pioneers in this area, but are also the countries with more fulsome implementatation of these policies.(17–20) In the last decade, each country has developed and implemented divergent policies to regulate the participation of for-profit insurance companies and address challenges related to health-system financing in their countries. This comparative context offers a unique opportunity to assess what values play a role in policy decision-making about health system financing and how and under what conditions policymakers use values to inform policy decisions.(19–21)

The focus of this study is to understand how and under what conditions socially and politically declared values are used in making decisions about health-system financing for two specific decisions in Chile and Colombia. The findings of this research, in addition to the analysis of interviews in our case study (see chapter 4) which emphasizes the influence of undeclared values, addresses an important knowledge gap and provides key insights for stakeholders and policymakers in Latin America engaged in policy development about health-system financing.

Methods

I conducted a discourse analysis using policy documents and media coverage from Chile and Colombia to identify what values have been articulated in policy decision-making about health-system financing and to determine whether and how those values have been influential.

Discourse analysis is a method focused on understanding how language is used in different contexts and across a diverse range of sources.(22,23) Discourse analysis provides a way to

identify ideas being expressed, as well as their purpose and intent, and in doing so, conflicts, tensions and oversights can be revealed.(24,25) In this study, discourse analysis will be used to identify the perspectives underlying the values used to inform health policy decisions, the purpose of those decisions, and the intention of including some values to achieve policy goals.

The discourse analysis was operationalized within a multiple-case embedded study design (26) with two cases and two embedded units within each case. The choice of a multiple-case study design was driven by the comparative nature of our research question and the ability of this design to produce robust results.(26) An embedded design was preferred given the nested nature of the context in which policy decision-making about health-system financing takes place in each of the country cases.

Case selection

The role of values in decision-making about health-system financing in Chile and Colombia were selected as the cases for this study because, although these countries introduced similar health reforms in the 1980s and 90s, they later diverged in their implementation. Chile, after the return to a democratically led government, has focused on guaranteeing healthcare for a group of prioritized diseases and on creating a fund to cover high-cost technologies (e.g., for diagnosis) and treatments.(27) In contrast, Colombia has worked on implementing the constitutional mandate of the right to health and establishing boundaries to its health benefits plan.(18,28)

Within each country, I chose two policy decisions as embedded units. Both decisions in each country needed to represent a significant shift in health-system financing policy as part of the health-system reforms. In each country, I selected one broad-reaching structural political decision (affecting financial arrangements as well as delivery and governance arrangements), and another

with a narrower focus on resource allocation within the context of the broader structural reforms. Both of the structural decisions were implemented within the last 10 years, while the narrower decisions were made (since 2015).

In Chile, for the structural political decision, I selected the development and implementation of the Universal Plan of Explicit Entitlements (AUGE or GES), which is a universal care plan designed to make medical coverage available to all Chilean citizens suffering from one of a specified, and growing, list of diseases (80 in 2018). For the second decision, I selected the approval of a law mandating universal coverage of technologies for high-cost diseases (known as the Ricarte Soto Law), which provides financial protection for the diagnosis and treatment of specific high-cost diseases among all citizens regardless of sector affiliation (public or private) or socioeconomic status.

In Colombia, for the structural political decision, I selected the declaration of health as a fundamental right, which implies a change in the notion of health as a public service (first with the rule T-760 and later with the Statutory Law). For the second decision, I selected the mechanism established by the Health Ministry to explicitly exclude technologies that cannot be funded within the available resources of the publicly financed health system.

Sources of evidence and sampling

The search strategy to identify documents (newspaper articles, published literature, policy documents, and other types of grey literature) consisted of four steps for each decision. First, a search of the LexisNexis Academic online database was used to identify media coverage (see Table 1 for details of the search strategy). Second, given that LexisNexis does not recognize all the newspapers in Chile and Colombia, I also performed the search strategies using the search function

provided on the website for each of the major newspapers and magazines in Chile (e.g., El Mercurio, La Nación, La Tercera) and Colombia (El Espectador, El Tiempo, Semana). Third, I searched published literature using the MEDLINE bibliographic database and the search strings outlined in the first step. Fourth, our search for grey literature focused on policy documents, including press releases, transcripts of hearings or congress debates, and other relevant documents. These documents were identified through purposive searches of websites of governmental institutions and relevant stakeholders (see Appendix 1 for a list of websites explored), as well as public documents identified through in-depth qualitative interviews that I conducted as part of a separate qualitative case study, which is presented in Chapter 4.

All the policy documents and media coverage captured by the search strategy were assessed by CMV and classified as "potentially relevant" if authors of media texts and policy documents provided insights about the identification, definitions, explanation, understanding and use of values about one of the four policy decisions selected for this study. The full text of all documents classified as "potentially relevant" were reviewed for inclusion, and relevant data were extracted from all the documents included by CMV. During this stage, I included all the laws regarding the four policy decisions as well as the transcripts of hearings and Congress debates. Given that many of the remaining policy documents and media coverage included the same or similar information, I purposively sampled those that provided new insights about the four decisions selected as the embedded cases.

Data analysis

A thematic analysis was conducted using a constant comparative approach for each case study. Information was coded using three frameworks: 1) Kingdon's government agenda-setting

framework;(29) 2) the 3I+E framework which refers to variables related to institutions, interests, ideas and external factors that influence policy development and implementation;(30) and 3) a framework I developed through a critical interpretive synthesis (CIS) in Chapter 2 which organizes the societal values involved in the policy decision making about health-system financing in Latin America.

Kingdon's agenda-setting framework uses three 'streams' of factors (problems, policies, and politics) to explain why some issues garner government attention (what Kingdon calls the governmental agenda) and why some issues are elevated to the point of being up for active decision (what Kingdon calls the decision agenda).(29) The framework includes three streams: problems, policies and politics. Problems are identified as coming to attention through focusing events, changes in indicators or feedback from the operation of current programs. Under the policy stream, possible policies to address the problem emerge from diffusion of ideas in a policy arena, communication and/or persuasion and feedback from current programs. Within the politics stream, issues are driven by events within government, swings in national mood and changes in the balance of organized forces. The governmental agenda is influenced by the problem and politics streams, while issues are elevated to the decision agenda through 'coupling' of all three streams, which is often accomplished by a policy entrepreneur who influences each of the streams. The Kingdon framework was applied to explain how values were used in framing problems, proposing solutions, and motivating politicians to take action to elevate the issues from the governmental agenda to the decision agenda.

The 3I+E framework focuses on the role of institutions, interests, ideas, and external factors in shaping policy choices.(30) Broadly, the framework considers institutions to be government structures (i.e., how and by whom decisions are made), policy legacies, and policy networks.

Interests include groups of people who may benefit or be harmed by a policy decision and may mobilize politically for or against this decision (e.g., patient groups, civil society). Ideas include values and beliefs of policymakers, stakeholders and the public, as well as ideas about 'what is' such as research evidence and tacit knowledge from those working within or making decisions about health systems. External factors are those outside of political processes (e.g., recessions, and court decisions) that can affect the choices made by policymakers at any given time. The 3I+E framework was applied to the four units to explain why the particular decisions were made and how values were used in the policy development and implementation.

Lastly, the framework I developed in our CIS explains how and under what conditions societal values have informed decisions about health-system financing in Latin American countries. This framework considers four categories: 1) goal-related values (i.e., guiding principles of the health system); 2) technical values (those incorporated into the instruments adopted by policymakers to ensure a sustainable and efficient health system); 3) governance values (those applied in the policy process to ensure a transparent and accountable process of decision-making); and 4) situational values (a broad category of values that represent competing strategies to make decisions in the health systems). Values in each category play different roles in agenda setting, policy development and implementation under certain conditions as international influences (e.g., from the WB, IDB, WHO, or UN), the type of health system financing, the ideology of the current government, or the influence of different interest groups. I used this framework to analyze how each category of values was influential in the agenda setting and policy development and implementation of the four decisions, and the conditions under which those values informed the policy process.

Analysis of the data

Data was initially examined through an open coding process where the codes were reviewed by grouping themes that are similar theoretically or connected in meaning, using the three frameworks outlined above. I created a list of codes that consist of a catalogue of themes, issues, accounts of values, and statements that relate to the process of policy decision-making across the cases. I organized the information from the conceptual mapping chronologically and created a summary consisting of the dates of each event occurrence, a description, the organization/institutions involved, historical references of the event (e.g., media coverage) and key information related to each of the analytical frameworks. Finally, I used all this information to develop a narrative that provides a thematic analysis of the policy and public discourse related to the role of values in each of the four units of analysis.

Results

A total of 376 documents were reviewed (149 for Chile and 227 for Colombia), from which I purposively sampled 113 for the analysis (40 for Chile and 73 for Colombia). The documents reviewed were newspaper and magazine articles (n=325), journal papers (n=18), laws/statutes (n=12), stakeholder's positions (n=8), transcriptions of conference proceedings (n=5), governments documents (n=4), transcriptions of hearings (n=2), and international agency documents (n=2) (see Table 2 for details about the type of documents reviewed for each policy decisions).

Main findings on how values are used to make decisions about health-system financing in Chile

Context

In the 1980s, Chile implemented a reform of the health system, which had been mostly publicly financed until then. In 1981, private health insurance was introduced, as well as the market mechanisms that regulated the level of protection of health. Since then, a two-tiered health system has existed in Chile, and citizens can be affiliated either with a single national public insurer, the National Health Insurance Fund (Fondo Nacional de Salud or FONASA), or with private health insurance institutions called ISAPRES (Instituciones de Salud Previsional), which operate under the logic of premiums adjusted to individual risk.(31–34)

At the end of the Pinochet dictatorship in 1989, the period of transition to democracy was led by four consecutive governments belonging to a coalition of centre and centre-left parties. The first two transitional governments implemented minimal changes to the health system, despite their market-oriented nature. The established health system had built up resources (e.g., administrative capacities of the government), incentives (e.g., economic benefits to interest groups such as insurance companies, which enhanced their power and influence in the system) and learnings about the system (e.g., the importance for the middle and upper classes to be able to access a different levels of service provided by the private for-profit sector).

The level of coverage offered by ISAPRES was derived from both the amount of monthly contribution or premium and an individual's risk (as estimated by their age, sex, family medical history, and other factors). There was no established minimal coverage, and the law allowed for the exclusion of pre-existing health conditions.(35) In contrast, public insurance provided universal access to a fixed basket of services.(31,36)

As a consequence of this "voluntary" and "market regulated" health system, FONASA provided healthcare coverage for the majority (67.4%) of the Chilean population, while ISAPRES covered 18.9% of Chileans (the remaining 13.7% belong to another insurance system for military

forces).(37) As would be expected, those receiving coverage through ISAPRES are individuals from the top-two income quintiles, with a higher proportion of men and youth than the average Chilean population, which represent those with the lowest risk profiles in the population.(33)

First embedded decision: Universal Plan of Explicit Entitlements (AUGE/GES Plan)

In the 1990s, politicians and stakeholders continuously criticized the performance of the Chilean health system given the feedback about how the system was failing to provide timely access to needed services. Values played a significant role in framing the problems of the Chilean health system and getting them on the governmental agenda. The issue then moved to the decision agenda when the elected President, Ricardo Lagos, proposed a health reform to address the failures of the health system and established an inter-ministerial committee to generate a policy proposal.(35)

Goals-related values such as accessibility, equity, quality, solidarity, and universality were used to frame the problems and highlight their importance (see Table 3 for a description of how values were used). The conditions under which these values were used are related to their lack of achievement, which defined the principal challenges faced by the Chilean health system. For instance, although Chileans were not technically excluded from access to the health system for any specific individual characteristics (e.g., ethnicity, income, sex and gender, etc.),(7) problems were framed as the lack of accessibility and universality due to lack of coverage for some groups. For example, many receiving healthcare through the ISAPRES lacked coverage for certain diseases and health conditions, such as expenses related to HIV/AIDS. In addition, some populations faced higher premiums, including older adults who were afforded fewer benefits and coverage unless they opted to pay higher premiums, and women of childbearing age who were required to either

pay higher premium rates or opt for health plans called "without a womb," which excluded coverage of pregnancy-related medical care.(35,38)

The proposal of the President Lagos was composed of five major reform projects, which included a Compensation Solidarity Fund to redistribute resources from the private to the public sector, and a plan called Universal Plan of Explicit Entitlements (AUGE) that would guarantee coverage under the public provision system for 56 of the country's most burdensome diseases. All of the projects garnered political support from the Congress, except for the Compensation Fund which was opposed by parties on the right of the political spectrum.

The passage of the AUGE/GES Plan is explained by factors related to institutions, interests, ideas and external factors (see appendix 2 for a description of the main factors that led to the policy decision). Institutional and ideational factors were essential for its development. The most important institutional factors were the consistent and energetic role of the President Lagos, who acted as a policy entrepreneur to mobilize support for the issue to be addressed along with the Senate's effort to mediate the conflicting interests of stakeholders and make acceptable modifications to the proposal, such as the elimination of the compensation fund.(35,39–45) Moreover, ideational factors, principally the use of the right to health rhetoric in the discussion of the reforms, explicitly identified several values as key goals to achieve for the health system (i.e., accessibility, financial protection, quality, and timely access) for a prioritized list of diseases and medical conditions among all FONASA and ISAPRES affiliates.(46,47)

The definition of this prioritized list of diseases and medical conditions, besides the baskets of services guaranteed by the plan, were informed by a set of technical values related to their evidentiary support (e.g., based on effectiveness and cost-effectiveness) and the relevance/importance to public health goals. These values were made influential under the

condition of an identified need for pragmatic instruments to inform policy development. The process also considered the social participation in the form of attending to citizens' demands for coverage to certain diseases, such as cystic fibrosis and multiple sclerosis.(35,48–52)

The AUGE/GES plan was of great significance from a legal perspective, as it was the first instance not only in Chile but in all Latin American countries to adopt a rights-based approach to health policy through legislation. As such, whereas the right to health of citizens remained largely undefined or implicit in legislation, the AUGE/GES policy clearly articulated these values during policy development and implementation.(35,51) Values used to frame the problems in the stage of agenda setting were almost completely represented in the policy development and policy implementation except solidarity, which was abandoned when the government withdrew the compensation fund initiative.

Second embedded decision: Fund for health coverage of high-cost diseases (Ricarte Soto Law)

As outlined in table 4, the Ricarte Soto Law emerged as a response to a focusing event. When the journalist Ricarte Soto was diagnosed with lung cancer he became aware of the economic barriers that patients like him face when trying to access to needed treatment, given that some high-cost treatments were not included in the AUGE Plan.(53) This awareness led the journalist to promote the conditions for a social movement advocating for a policy that guarantees access to treatments for high-cost diseases, which subsequently garnered political support in the form of a programmatic proposal of the presidential candidate, Michell Bachelet, who promised a fund to cover drugs associated with complex and high-cost diseases.(54)

Given this, the key value articulated about the proposed policy was equity. Equity was identified in relation to financial protection (i.e., that need and not ability to pay should determine

coverage for high-cost diseases), and also in relation to accessibility in the sense that patients with rare diseases could access the treatments they need in the same way that patients with more prevalent medical conditions.

The most important factors that explained the development of the Ricarte Soto Law are related to interests and external factors (see Appendix 2 for a description of the main factors that led to the policy decision). For interests, the key driving factor that drove and shaped policy change included strong social mobilization of patients' associations that garnered societal and political support. The key external factor affecting policy development was a change in government with the election of Michelle Bachelet, who since her presidential campaign had committed to advocating for a fund to cover the technologies needed by patients with high-cost diseases.(55,56)

Given this, equity was the value at the core of policy development for Ricarte Soto Law, but the conditions that shaped a significant opportunity for social participation and citizen engagement as a mechanism to ensure good governance also played a significant role. In particular, patient mobilization helped generate the initial attention towards the issues, but also garnered the political commitment needed to develop the policy. Moreover, having patients invited to participate in the process of defining the conditions included in the Ricarte Soto fund, improved the social perception about the capacity of the government to address important social needs.(57)

Analysis between embedded decisions

The AUGE/GES plan was oriented to improve equity by means of the redistribution of resources in the health system. This included incorporating care for the poor as part of a universal system where those with less income are empowered to access goods and services on equal conditions with the high-income population.(58) However, given that the diseases and conditions

covered by the AUGE/GES plan were defined by technical values in relation to evidence of effectivness and cost-effectiveness and relevance/importance to public health goals, patients with conditions not prioritized in the AUGE/GES plan ultimately were faced with a lack of timely access to the healthcare, care that was of poor quality, lack of financial protection, and an inability to advocate for their right to health through judicial mechanisms. As a result, the structural AUGE/GES policy decision subsequently created the conditions for a new equity-related problem. Over time this problem was brought to prominence on the government's agenda by Ricarte Soto who sparked action and created the opportunity and conditions needed for patients with high-cost diseases to advocate for appropriate healthcare in the Chilean health system (see Figure 2 for a timeline of the principal events in both embedded decisions).

As noted above, the development of the AUGE/GES plan relied on, principally, technical values such as evidence about effectiveness and cost-effectiveness and relevance/importance to public health goals, which helped to define the diseases, conditions and baskets covered by the plan. In contrast, evidence about cost-effectiveness and relevance/importance to public health goals were not prioritized in the Ricarte Soto Law because several technologies and interventions for high-cost diseases are, by definition, expensive and therefore, a cost-effectiveness criterion cannot help to decide which technologies to cover. However, evidence-based values were still prioritized during policy development for the Ricarte Soto law given the importance of the evidence about effectiveness and safety of the interventions proposed. Additionally, while the AUGE/GES plan development depends primarily on technical values, the Ricarte Soto relied principally on governance values such as social participation and patients' engagement. The reason is that in the Ricarte Soto Law the technical values could not exclusively be used to drive a

successful and legitimate policy, which required patient participation to jointly make decisions about the prioritization and to ultimately to ensure public approval.

Main findings on how values are used to make decisions about health-system financing in Colombia

Context

The current health system of Colombia was enacted by the Law 100 of 1993 and is anchored in a model of "managed competition," and in the Constitution of 1991.(59,60) Since implemented, the two-tiered insurance scheme of Law 100 has had to balance the values of the private market and the health of the population, which led to the need for governmental stewardship emerging as an essential value for ensuring that private health insurers and providers act in the public interest.(60,61) In addition, 13 guiding values were articulated as part of the law, which included a mix of governmental, technical, situational and goals-related values. From these, the principal values underpinning the social insurance system (as explicitly mentioned in Law 100 and the Constitution) included efficiency, equity, quality, solidarity, and universality.(59,62)

This mixture of values involved in the health system is related to four complex and inter-related contextual factors which are the conditions that shaped the policy-decision making processes about health-system financing in Colombia. The first factor is the weakness of the political system, which was driven by a lack of interest of legislators in pursuing national policy initiatives given that small parties turn over frequently, a lack of clear policy platforms, and that the widely-held view of the Congress as being corrupt. As a result, the Congress was very weak in carrying out the core functions of lawmaking or checking executive power. In addition, the concentrated power of the president was primarily unchecked by other elected officials, which

further contributed to the overall weakness of the political system and the legislators who work within it. The second factor is the strong role of the judicial system in the health policy process, which provides the Constitutional Court a great deal of legitimacy in shaping health policy in the country.(63) The third factor is the introduction in the Constitution of 1991 of the tutela, which is an informal and expedited injunction that allows individual claims for judicial protection when fundamental human rights are threatened by the state or by a third party.(60) The introduction of this provision opened the door to a significant increase in litigation in relation to rights enshrined in the Constitution, including those related to the right to health (see Appendix 3 for a description of the main factors that led to the embedded decisions).(64)

The final factor is related to the structure of the health system. Law 100 defined benefits packages to be provided under a national insurance scheme through an individual capitation scheme that includes a contributive regime for employees and a subsidized regime for unemployed and low-income families. The benefits of the subsidized basket of health services were approximately half the benefits in comparison to the contributive regime's basket,(61) which created an important source of inequity in the design of the system itself. However, the health system was built on the assumption of the progressive improvement of universality and equity, until the elimination of the barriers to access to a unified basket of health services in the year 2001.(60,61)

First embedded decision: Declaration of health as a fundamental right

Between 1999 and 2008 the number of tutelas filed regarding health claims had increased 300%.(60) Some of these tutelas included claims for healthcare services "excluded" from the benefits plans of each regime. However, most of the claims were focused on enforcing coverage

for technologies and services already included in benefits plans that health insurance companies unlawfully refused to provide.(60,61) For example, between 2006 and 2008, 75% of surgeries, 63% of diagnostic tests, 67% of medications, and 78% of procedures sought through tutela were part of what plaintiffs had a right to under their respective benefits baskets coverage.(61)

In addition, insurance companies promoted the appearance of so-called 'grey zones', which referred to uncertainty about the inclusion of some services in the benefits plan and which left individuals with no sense of the level of health care they were entitled to.(60) Moreover, if a tutela for services in the 'grey zone' was granted, the public fund (FOSYGA) was required to reimburse private health insurance companies after they have delivered "excluded" healthcare services to the patients whose the right to life was at stake.(60) As a result, the system provided an incentive for insurance companies to deny reimbursement for services in the 'grey zone' so that the publicly-financed system would ultimately cover the costs (see Appendix 3 for a description of the main factors that led to the policy decision).

The increase in tutelas revealed an important problem in the Colombian health system, which was framed in two different ways. The first was an issue in relation to the violation of the right to health and the role of the Constitutional Court in enforcing it. This resulted in a framing of the lack of achievement of the goals of the health system given that the legal rules for the provision of healthcare were not being upheld and judges had to intervene on individual cases.(65) The second framing was that the increase in tutelas implied a threat to the sustainability and efficiency of the health system because of the issue of insurance companies not paying for services in the 'grey zones' of care. As a result, the publicly-financed system was paying twice for the costs of the healthcare. Both components of the problem drew consistent attention from the media, as

well as critiques of the government for their lack of enforcement of the legislation in the health system.

In this scenario, the Constitutional Court emerged as a key player in the health policy process due to its favorable public opinion, independence from the executive and veto power, to formulating health policy to declare and enforce the right to health.(66)

Specifically, in 2008 the Constitutional Court passed the Rule T-760, which was a project to eliminate the structural causes of non-compliance with the healthcare legislation. Through Rule T-760, the Court ordered a series of structural changes to the health system, some of which consisted only of a restatement of injunctions contained in the legislation.(67) For instance, the Court ordered the government to take the necessary steps to unify the two regimes of health coverage, and to update the benefits included in the new unified plan.(65,68) However, in 2010 the number of tutela lawsuits began to escalate again and reached levels similar to those in 2008, with increases of approximately 107,000 tutelas each year between 2010-2014,(69–73) The reimbursments to the private insurance companies during 2009 were close to US$963 million, whereas in 2006 they were close to US$162 million, a 494% increase over three years.(60)

Two initiatives were developed to address these problems with one by President and the other by Congress (See Figure 3 for a timeline of the principal events in both embedded decisions in Colombia). Following those failed initiatives, the government of Juan Manuel Santos presented two bills to the Congress in 2013, which included a Statutory Law and an Ordinary Law,(74) of which only the Statutory Law was passed after changes introduced by the Constitutional Court. The Statutory Law declared health as a fundamental right and de-incentivized the surge of litigation on costly health care services by forbidding the use of public funds to reimburse cosmetic and experimental medical treatments demanded by patients.(60,75,76)

The decision of declaring health as a fundamental right was influenced by factors related to institutions, interests, ideas and external factors (see Appendix 3 for a description of the main factors that led to the policy decision). However, ideational and external factors were the most salient for enabling and shaping the policy decision. For ideational factors, the most important was the change in the ideas facilitated by the intervention of the Constitutional Court about the character of fundamental of the right to health (i.e., the right to health not only enforceable given its connection to the right to life but enforceable by itself). Relatedly, the most relevant external factor was the active role of the judicial branch in enabling the process towards the Congress having to make the decision to declare health as a fundamental right.

Values aligned with the ideology of the Constitutional Court were the principal conditions under which values influenced Rule T-760 and the Statutory Law. With the Rule T-760, the Court highlighted and entrenched the value of equality by trying to decrease the number of tutelas by guaranteeing the same health benefits to all the Colombians, and not only conceding individual treatments, that could not be universalized, to people who has access to justice, which historically has been the people with better socioeconomic status.(61,77–79)

With the Statutory Law, the Constitutional Court considered a range of values, with fairness, gradualism, and transparency being the most important (see Table 4 for a description of how values were used).(61,66) According to the Court, the Colombian society does not have agreement on fine-tuned principles for how to equitably meet the health needs of its population (e.g., by determining whether and how to prioritize the needs of those with the lowest socioeconomic status when needs of all cannot be met). As a result, the court based its decision on values related to fairness, but in relation to the fairness of the decision-making process. This meant that the process was to be underpinned by a "transparent rights-based rationality", where

policymakers need to analyze if the objective of the existing policy results in the protection of the right to health or not, and to make the basis on which decisions are made publicly available.(61,66)

In its decision-making process, the Court considered gradualism in the sense of recognizing that rights are not absolute, and that the development and expansion of the protection of the right to health implies certain limitations, but that these limitations should be accompanied by proof of progress.(66)

Second embedded decision: mechanism of exclusion of technologies to be funded with public resources

According to the Constitutional Court, feedback from the operation of current programs highlighted that previous definitions of benefits packages lacked transparency and the use of evidence-based mechanisms for prioritization of what technologies should be publicly funded.(61,80) In addition, the Court considered that the process of defining the benefits baskets struggled with two important problems. The first problem related to how reimbursements for provisions of services not included in the baskets were handled, which opened the door to massive corruption and mismanagement in the health system (e.g., the 'gray zones' created by the insurance companies).(61,81,82) The second problem identified is that the judges who had to decide if a tutela should be granted to a plaintiff do not know if the technology or service demanded is medically or financially reasonable. As a result of these problems identified by the Court, it asked the executive to develop and implement a technical-scientific mechanism to define those services excluded from the core of the right to health, which would mean that patients were entitled to all technologies and services except those that are specifically excluded from the benefits plan.(76) The policy response came in 2017 when the health ministry enacted Resolution 330 which adopted

a public, collective, participatory, and transparent technical-scientific procedure, designed to determine the services and technologies that should be excluded from publicly financed programs.(83,84)

As outlined in Appendix 3, the key factors that ultimately contributed to the policy decision for how to define excluded technologies were the development of the jurisprudence about the right to health and the influence of the Constitutional Court on the decision-making process. The Constitutional Court through the Statutory Law imposed rules on the Health Ministry to design the mechanism of exclusions, requiring the government to finance all services prescribed by physicians except in four situations: 1) experimental treatments, 2) treatments provided abroad, 3) cosmetic treatments, and 4) treatments without any proven effectiveness.(85)

The procedure of exclusions highlighted the values of social participation and transparency, which were used under the condition of legitimizing the process of prioritization. The rationale was that these values can help citizens (particularly those negatively affected by the exclusions) to understand how decisions were made and whether they were based on reasonable criteria and scientific evidence,(86,87) as well to balance different points of view and perceptions when making decisions. For example, a debate about reconstructive breast surgery concluded with the decision of the court that the nature of the cosmetic or reconstructive surgery would be decided on scientific criteria and not supported in administrative or financial considerations of the insurance companies nor the patient's opinion. The court highlighted that cosmetic surgery was excluded, while reconstructive or functional surgeries were understood to be included and under the responsibility of the insurance companies.(88,89)

Analysis between embedded decisions

For approximately 15 years, health policy development about health-system financing in Colombia has been criticized for its insulation from public debate, social participation, and accountability.(61,66) However, in 2008,the Constitutional Court passed the Rule T-760 ordering policymakers to adhere to the rules of equality and quality contained in Law 100, which policymakers had not implemented given that rules were viewed as threats to the sustainability and efficiency of the health system.(60,61,81) Since that time, a debate continued between policymakers in the executive branch who prioritized values such as efficiency and sustainability, and the judicial branch which emphasized values such as the dignity of life and the right to health. These discourses have not been amalgamated to develop policies that solve the principal problems of the Colombian health system, most notably the financial barriers to healthcare faced by many citizens, the financial sustainability of the system and the regulation of the private health insurance market. Instead, these problems intensified, and the executive branch proposed laws to solve them, which were guided exclusively by the same technical values, which the Court has declared unconstitutional given that they do not consider the right to health as the center of the health policy.(65,90,91)

In the declaration of health as a fundamental right, the Court decided on the philosophical terms about the future of the health system, explaining why the Statutory Law states that all technologies and services must be funded with public resources until a participatory evidence-based mechanism explicitly excludes some of them. In the development of the mechanism to explicitly exclude technologies which cannot be funded within the available resources for the public health system, the health ministry transformed those philosophical assumptions into achievable and measurable goals, and therefore, technical values related to ensuring evidence-based decisions, by considering effectiveness and safety, came to play a role in deciding which

technologies to exclude.(61) Given that the implementation of the mechanism to define exclusions is very recent, there is not enough information to analyze if the health ministry is consistently applying the values guiding the Statutory Law, if the strategy that the Court promoted in the Statutory Law is feasible within the budget constraints of the Colombian health system, and if it is resulting in pressure from different interest groups.

Cross-country analysis

Both Chile and Colombia have focused health-system financing reforms on establishing mechanisms and policies to guarantee equitable access to healthcare within the constraints of limited public resources. In comparing the two cases and the two embedded decisions in each, two key similarities and one difference emerged.

The first similarity is the role of the right to health to guide policy development in both countries. However, while the focus was the same, the institutions from which they emerged differed, with the rhetoric about the right to health being introduced by left-centered-aligned governments in Chile, while in Colombia the policies were introduced as a form of judicial activism of the Constitutional Court given inaction from the executive branch of government. As a result, the way in which Chile addressed the right to health was as something concrete that has specific values that correspond to verifiable achievements. In contrast, in Colombia, the right to health appears as something more philosophical, with several values not clearly articulated in the policy, which would therefore requires executive branches of government to transform it into policy.

The second similarity is the recent introduction of social participation in the process of policy development in both countries. In Chile, participation in the actual development of the

AUGE/GES plan consisted of engaging a group of experts as opposed to an open, participatory process. However, with the Ricarte Soto Law having been motivated by social mobilization, the policy development therefore was also based on social participation as it was used to legitimize the policy process and help to decide the conditions and technologies funded by the Ricarte Soto Fund. In Colombia, the processes of policymaking about health-system financing had historically lacked social participation of patients and citizens, as well as experts from outside of the government. However, in the cases studied, the Constitutional Court introduced broad social participation in the deliberations about establishing and implementing the orders of the Rule T-760. This was explicitly operationalized in the Statutory Law through a participatory mechanism that was used to decide on the technologies to be funded with and excluded from public resources.

Lastly, the main difference in the cases relates to the value of solidarity. In Chile, the value of solidarity was explicitly presented in the agenda setting of the AUGE/GES plan but was subsequently withdrawn during the policy development phase. In contrast, in Colombia solidarity does not appear in the decisions analyzed but is readily identifiable as a core value of its health system. For example, the fact that contributions of all formal employees collectively finance the Colombian health system is a key example of how solidarity has been entrenched as a value in how the system is financed. Therefore, while entrenching solidarity as a value remains as an unaccomplished piece of policy development in Chile, it is not a similar priority in Colombia given that it is already an identifiable core value in the system.

<u>Discussion</u>

Principal findings

Chile and Colombia, which implemented market-oriented policies in their health systems in the 1980s and 90s, have moved toward establishing policies to guarantee equitable access to healthcare within the constraints of limited public resources. In this multiple-case embedded study, I conducted a systematic analysis of two health-system financing decisions in each country that were focused on enhancing equitable access to healthcare and used analytical frameworks to identify how values have informed government agenda setting, policy development and implementation of these decisions.

In both countries, the development and implementation of policies protecting the right to health created a discourse about what should be included or excluded from this protection onto each government's agenda. In Chile, the AUGE/GES plan, which covers a basket of services for a set of prevalent diseases, implied the exclusion of rare diseases and high-cost treatments. The situation provoked the social mobilization of patients with high-cost diseases and the subsequent Ricarte Soto Law to fund diagnosis or treatments for these diseases. The development of the Ricarte Soto Law, therefore, implied a shift from strictly technical values (which decided the diseases and technologies covered in the AUGE/GES plan) to values like social participation and equality. Principally, the Ricarte Soto Law implied a different approach to equality, given that in the AUGE/GES plan equality was considered as the same basket of services for all the Chileans independently of income and system of insurance, whereas in the Ricarte Soto Law the approach focused on providing needed healthcare independently of the prevalence of the disease and the cost of the treatment. This shift of values may be explained by the fact that the AUGE/GES plan was developed to address the principal public health problems of Chileans, while the Ricarte Soto was more focused on giving answers to social nonconformity and to garner favorable public opinion by the President Michelle Bachelet. This affirmation is corroborated by some stakeholders

in Chile who have highlighted that the $200 billion Chilean pesos (USD $400 million),(92) used to cover a total of eleven diseases,(93) is not enough to cover the needs of patients with high-cost diseases.

In Colombia, the decision of considering health as a fundamental right required a mechanism to explicitly set boundaries of the right to health and determine the characteristics or values that make a technology or service deserving to be protected by the right to health and covered with public funds. In this case, the second decision I studied implied a shift from the goal-related values dimension (the declaration of a fundamental right) to technical and governance values dimensions (e.g., evidence-based, rationality, social participation, stewardship, sustainability). In both decisions, the Court has played less of a role as a source of a potential veto for specific legislation, but rather as the most important actor in health policy making.(94) The Court reviews the laws and analyzes whether they are reflective of the values of the Constitution and of the Constitutional Court itself. However, as similarly highlighted is a recent study of Hawkins & Alvarez, the Court lacks the ability to consider scientific evidence or technical values (e.g., cost-effectiveness of the interventions, sustainability of the health system) and therefore, its decisions put significant financial pressure on the health system, and represent a "suboptimal means" to develop health policies.(94)

In the cross-country comparison, I identified as a common aspect the introduction of the rhetoric about the right to health to guiding the policymaking in both countries. However, the approaches and the stakeholders that introduced this rhetoric in the policy process are different. In Chile, the approach was more pragmatic and was linked to discussions at the level of the executive branch (i.e., the president, the health ministry, and the finance ministry). In Colombia, the approach to the right to health was of a philosophical order and was embedded in broader discussions about

what the health system ought to achieve, and was promoted by the judicial branch through the Constitutional Court. This is a unique finding to this study, as it has documented how a non-traditional branch of power may strongly influence the policy decision-making in some countries.

Additionally, I identified that the value of social participation has been recently introduced in the process of policy development in both countries. Similar to our finding in Chapter 2, social participation has often been used as a strategy of the government to reinforce the symbolic identification of health with democracy, and to legitimize policy choices. Only recently, social participation has been recognized as a value that would improve the health system performance, and the achievement of health outcomes. In this approach, patients are no longer just defenders of their interests but are participants in a deliberative societal prioritization exercise with the goal of achieving common objectives and benefits.(54)

When the four embedded decisions are considered in the political context of each country, I identify that values entrenched through large structural reforms are key to shaping the many incremental changes made to health systems in subsequent years or decades. Therefore, these large structural reforms serve as inflection points in policy development as they determine the values that shape the health system over time. For decisions about the large structural reforms, it is the world views and values of policymakers who are strongly committed to the reforms (i.e., policy entrepreneurs) and the prevailing values of citizens and interest groups at the moment of the decisions that contribute to spurring such large changes that ultimately lead to the long-term entrenchment of these values.

Strengths and limitations of the study

There were three mains strengths of the study. First, the study design included the collection of data from multiple documentary sources, which allowed for the identification of consistencies and inconsistencies across sources, and the inclusion of different points of view. Second, the multiple-case embedded design allowed for the in-depth analysis of how values have informed policy decision-making about health system financing in Chile and Colombia. The design enabled the analysis within each decision in each country, between decisions in the same country, and across all the decisions in both countries. Third, the robust approach involved the analysis of four crucial decisions, which happened in different times, different countries and different contexts, and therefore allowed for analysis of how decision makers develop policies informed by values and translate them into something pragmatic. To this end, the embedded units of analysis were carefully selected to consider decisions rich in values, concepts, and worldviews.

There was one main challenge to this study, and it related to the novelty of the Ricarte Soto Law in Chile (enacted in 2015), and the mechanism to exclude technologies to be funded with public resources in Colombia (defined in 2016). Although it was possible to evaluate the context and the factors related to the agenda setting and the policy development, it was not possible to identify much information that would allow for contrasting different points of view or developing an in-depth understanding of the implications of their implementation. However, while revealing the challenges this poses for discourse analysis of publicly available documents, the findings from this study are complemented by those presented in Chapter 4 which used interviews to fill this gap.

Implications for policy and practice

The findings of this study are important primarily for stakeholders and policymakers in Chile and Colombia. For stakeholders, the findings provide an analysis about the values related to

the decisions in their countries that support their understanding of how particular proposals or initiatives should align with this national mood to influence the decision-making. For policymakers, the findings present different points of view of how technical, social, and political values are important to designing policies that meet the needs of the population and responding to citizens' preferences. Potentially, this study could help stakeholders and policymakers in other Latin American countries or other low-and-middle income countries in the world. For example, those countries confronted with discussions about the incorporation of values in policy decision-making processes, or in the development of policies to guarantee the right to health, might find the experiences of Chile and Colombia as a useful source of policy learning by comparing and contrasting to their situation.

Implications for future research

In Latin America, the identification of values in the policy decision-making process is an emerging field. Findings in this study may help to compare and contrast experiences about how values are used, not only in other policy domains in the Chilean and Colombian health systems, but also in other domains in social systems, such as education, social security, or child policy. Additionally, the framework developed in Chapter 2 and used in this study, is adaptable to be used in other fields and jurisdictions. Moreover, this study can serve as the basis for following how values are being incorporated to the decisions discussed here, or to determine if governments have changed the path of action in a different direction, prioritizing different sets of values according to specific situational factors.

Considering that this study focused on documentary sources, and therefore its scope is limited to declared values, qualitative approaches are needed to further explore and assess whether

values declared in the official documents were actually used in policy decision-making processes about health-system financing in Chile and Colombia. Exploring the undeclared values and perceptions of stakeholders and policymakers about the decisions discussed here might help to understand how and why values explicitly declared are indeed incorporated in the policymaking process, whether undeclared values are more, less or equally important in the policy process, and why some values are prioritized over others in specific decisions.

An additional field of inquiry was identified when analyzing the role of the judiciary system in the health policymaking. Commonly, research and debate on health policy recognize the legislative and executive branches as the more appropriate set of institutional structures involved in policymaking. However, I have identified that the judiciary branch may have an important role in the development of laws and health policies, such is the case of Colombia. This represents a significant gap in our understanding of how and under which conditions, judiciary branch plays a meaningful role in health policy decision making.

Conclusions

The study of values in the policy decision-making process in Latin America is an emerging field. Our effort to analyze health-system financing policies in Chile and Colombia using analytical frameworks related to government agenda setting, policy development and implementation and by considering the influence of societal values is a unique contribution to the body of knowledge in this field. As such, it is an opportunity to open further exploration of the role of values in different health decisions, political sectors besides health, and even other jurisdictions.

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Figure 1. Overview of multiple case embedded design

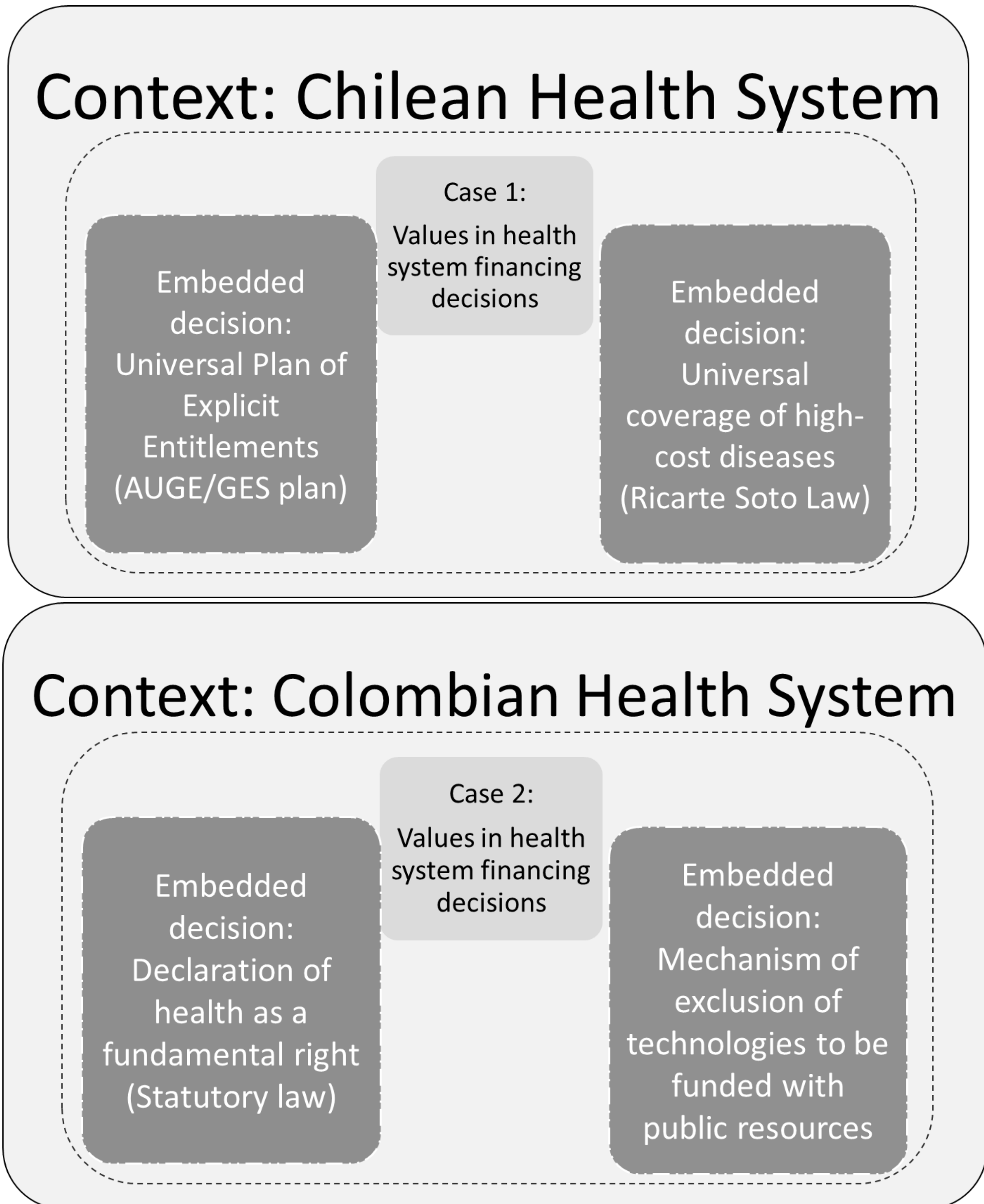

Figure 2. Timeline of the principal events in both embedded decisions in Chile

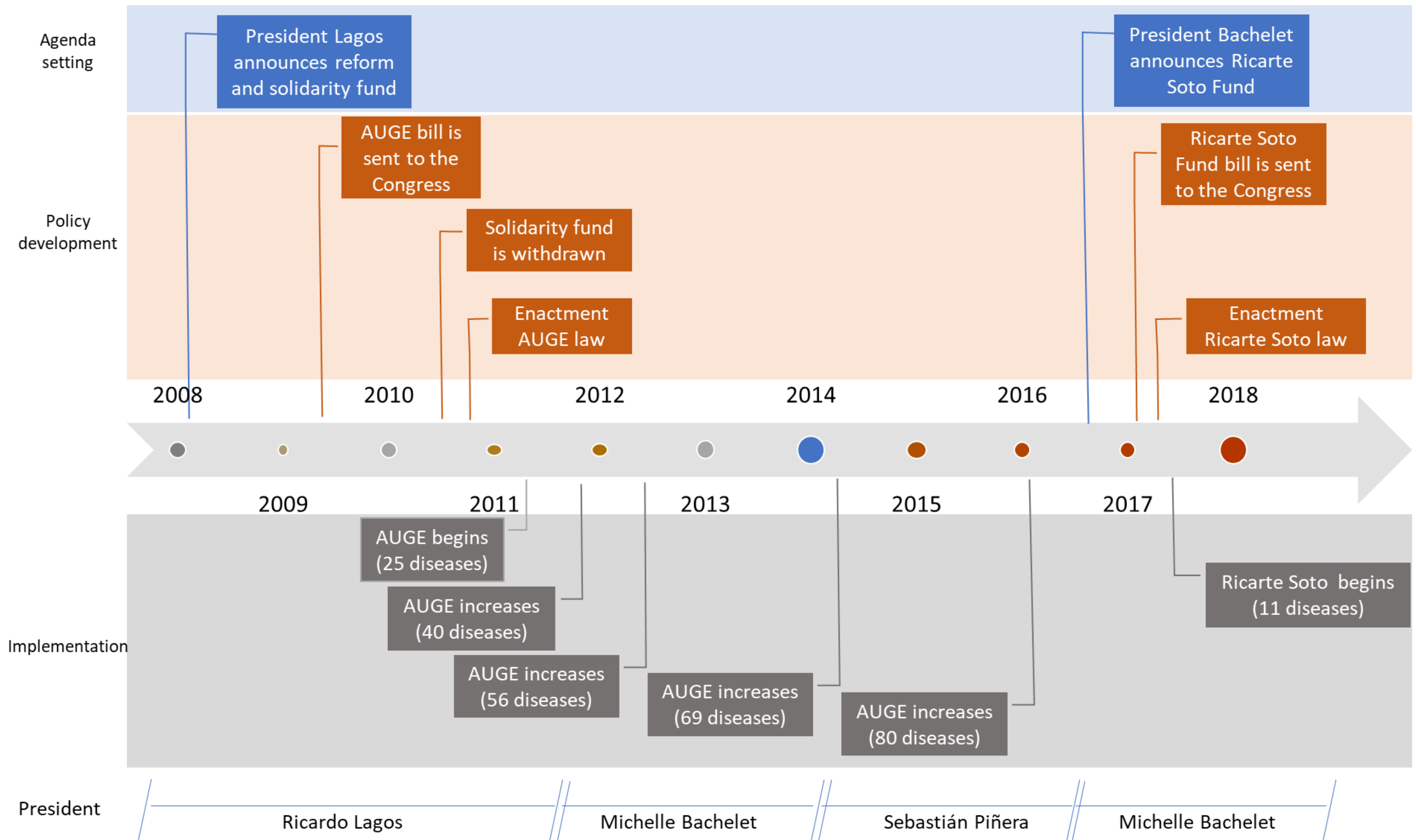

Figure 3. Timeline of the principal events in both embedded decisions in Colombia

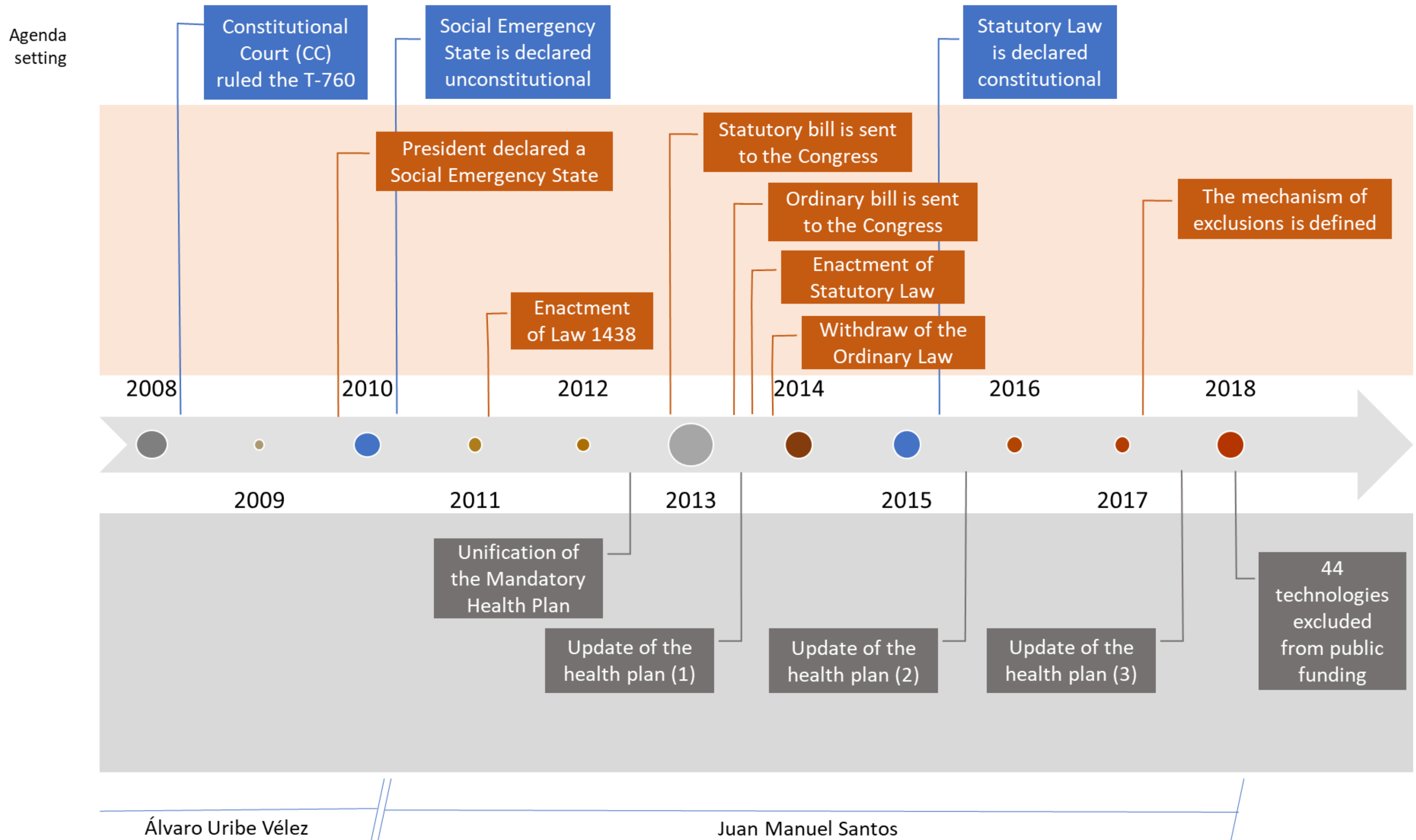
Agenda setting
Constitutional Court (CC) ruled the T-760
Social Emergency State is declared unconstitutional
Statutory Law is declared constitutional
President declared a Social Emergency State
Statutory bill is sent to the Congress
Ordinary bill is sent to the Congress
Enactment of Statutory Law
Withdraw of the Ordinary Law
Enactment of Law 1438
The mechanism of exclusions is defined
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Unification of the Mandatory Health Plan
Update of the health plan (1)
Update of the health plan (2)
Update of the health plan (3)
44 technologies excluded from public funding
Álvaro Uribe Vélez
Juan Manuel Santos

Table 1. Literature search strategy

Country	Decision	Search string	Sources
Chile	Decision 1: Universal Plan of Explicit Entitlements (AUGE/GES Plan)	"AUGE plan" OR "GES plan" AND Chile	Lexis Nexis Medline El Mercurio La Nación La Tercera Websites of key stakeholders
	Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)	"Ricarte Soto" AND Chile	
Colombia	Decision 1: Definition of health as a fundamental right	"T-760" OR "Ley estatutaria" AND Colombia	Lexis Nexis Medline El Espectador El Tiempo Semana Websites of key stakeholders
	Decision 2: Mechanism to exclude technologies to be funded with public resources	"exclusiones en salud" AND Colombia	

Table 2. Type of documents reviewed according to the country and the decision

	Chile		Colombia		
Type of document	AUGE/GES Plan	Ricarte Soto Law	T-760 & Statutory Law	Mechanism for exclusions	Total
Media	105	26	181	13	325
Laws, statutes	5	1	3	3	12
Transcription of conference proceedings	0	0	5	0	5
Transcription of hearing	1	0	1	0	2
Journal paper	5	0	13	0	18
Stakeholder position paper	2	0	5	1	8
Government document	3	0	1	0	4
International agency document	1	0	1	0	2
Total	122	27	210	17	376

Table 3. How values were used in each embedded decision in Chile

Decision	Values identified	Explanation of how the values were used	Example*
Universal Plan of Explicit Entitlements (AUGE/GES plan)	Goals-related values: • Accessibility • Equality • Equity • Quality • Solidarity • Timely access • Universality	**To frame health-system issues in meaningful ways for stakeholders and citizens** (7,32,33,35,38,41,43,95–98) • Stakeholders and politicians framed the problems as the lack of these goals-related values to highlight the relevance of the problems and the importance of addressing them	Accessibility and universality • Many people receiving care through the ISAPRES lacked coverage for certain diseases and health conditions and some populations faced higher premiums (e.g., the oldest and women of childbearing age).(35,38) Equality and equity • The high-income, lowest-risk population was predominantly insured by the private sector, which provide better health care quality, but low-income families and high-risk individuals were mainly affiliated to the publicly-financed system, which was perceived to provide sub-optimal care in terms of timely access and quality.(32,33) • Divergence of health outcomes in the population, with greater and faster rates of improvement among the top-income quintiles who accessed the privately-financed system than among lower-income quintiles who accessed the publicly-financed system.(7,35,97,98) Quality and timely access • Poor quality of providers and issues of timely access in the publicly-financed system (i.e., FONASA).(35,95) Solidarity • The over-allocation of resources to healthy and young individuals in the privately-financed system, which cannot then be shared with the sickest and lowest-income population accesing the publicly-financed system.(35,95)
		To guide policy development from the perspective of an enforceable right to health (99,100) • The right to health was disaggregated in goals-related values, which served to guide the design of the AUGE plan according to achievable and verifiable goals. Those goals were: 1) an	• “In accordance with the values and guiding principles defined by the government, an attempt is being made to create a new health system that: ensures the right to adequate health care; reduces inequalities in health that are avoidable and unfair (what are known as "inequities" in health); and is supportive, through an intentional effort so

Decision	Values identified	Explanation of how the values were used	Example*
		enforceable right to health; 2) the definition of treatment protocols and specific interventions necessary for treating the medical condition; 3) the adoption of maximum waiting times for each condition; and 4) the adoption of limits on out-of-pocket spending according to the family's income.(51,101)	that the most vulnerable have the same guarantees as the most favored"(99) • "For the Government, health is a right of the people. To safeguard the right to health it is not enough to declare this right, but it is necessary to establish explicit guarantees of access, timeliness, quality and financial protection, and generate the instruments for the effective exercise of these, providing users with the abilities and mechanisms to make them enforceable."(100) • The AUGE/GES plan set up a coverage floor that all insurers must satisfy.(35,51) This included a legal obligation for ISAPRES to adopt—at a minimum—the same legal guarantees as FONASA, which resulted in no ISAPRES beneficiary getting less coverage than what AUGE/GES requires. As an example, ISAPRES could no longer provide a woman of childbearing age with a plan without pregnancy-related coverage.(102)
	Technical values: • Cost-effectiveness • Effectiveness • Evidence-based • Financial protection • Public health relevance	**To guide decisions about the nature and scope of coverage** In determining the nature and scope of coverage, values were used: • as pragmatic instruments to develop the policy and decide which diseases and conditions should be included;(103) • as pragmatic instruments to define the basket of included services for each condition; and • to determine the feasibility of implementing some strategies over others.	• "The main prioritization criteria used by the Health Minister [MINSAL] and by the Consultative Council according to the law should be: 1) studies of the burden disease and risk factors, both expressed in DALYs (sum of the years of life lost, either due to premature death or disability, attributable to each pathology or risk factor); 2) efficacy and effectiveness of the benefits offered, according to evidence-based medicine criteria; 3) real capacity of attention of the health systems for each one of the pathologies or proposed conditions; and 4) criteria of social preferences"(103)
	Governance values: • Social participation • Stewardship	**To gain legitimacy in the policy development process** In the definition of conditions included in the AUGE/GES plan, values were used:	• The process considered citizens' demands for attention to certain diseases, such as cystic fibrosis and multiple sclerosis.(35,48–51) • "The legitimacy of the AUGE is, precisely, one of the most questioned points in the public debate. Workers and health professionals, and very particularly the medical association, have repeatedly pointed out that they were

Decision	Values identified	Explanation of how the values were used	Example*
		• as a strategy of the government to improve social perception about its capacity for responding to social needs;(35,48–51) and • as a part of the strategy to address those opposed to the AUGE/GES, who emphasized its lack of legitimacy.	excluded from the formulation process. It also seems that the population has a lack of knowledge or confusion of what AUGE means, which has been accentuated by public anti-AUGE campaigns, organized and financed by the medical association."(104)
	Situational values: • Free choice	**To oppose the policy development given that it contradicted strong policy legacies** • Opposers to the reform stated that the loss of freedom of choice of doctors was an unfavorable aspect of the reform.(103)	• Chileans consider the ability to choose their health provider as an important feature of the health system. This expectation from the system was contradicted in the AUGE/GES plan given that patients could only be treated by providers certified to treat AUGE conditions, which resulted in criticism of the plan from citizens.
Fund for health coverage of high-cost diseases (Ricarte Soto law)	Goals-related values: • Equity	**To frame health-systems issues in meaningful ways for stakeholders and citizens** The journalist Ricarte Soto framed the problem of the lack of coverage of treatments for high-cost diseases as an equity problem. The journalist highlighted that patients belonging to the private system had timely access to those technologies, but patients in the public system faced several barriers.	• "At some point, I felt uncomfortable about having the means to do everything quickly because in cancer you have to do everything quickly ... Then I said, why am I such an imbecile? if the problem is not that I receive this kind of care, the problem is that in Chile many cancer patients do not have the possibilities that I have," Ricarte Soto said.(53)
	Technical values: • Evidence-based • Financial protection • Safety	**To guide decisions about the nature and scope of coverage** In determining the nature and scope of coverage, values were used: • as pragmatic instruments to develop the policy and decide which diseases and conditions should be included; and • as pragmatic instruments to define the technologies and services covered.	• The criteria to decide which diseases include in the Ricarte Soto Fund was the financial impact of needed treatments on families. To decide which technologies cover with the fund, the criteria was the effectiveness of the intervention. • "Only medications that are safe and effective for patients according to scientific, economic and social criteria will be incorporated into the fund. The goal is to deliver medicines and high-cost nutritional supplements • that have proved effective."(105)

Decision	Values identified	Explanation of how the values were used	Example*
	Governance values: • Citizen engagement • Social participation	**To prioritize which conditions and technologies to include and to improve the acceptability of the policy** Participation of patients and citizens in the definition of conditions included in the Ricarte Soto Fund improved the social perception about the capacity of the government for responding to the social needs.	• "Today is an important and emotional day, because it combines the joy of seeing this yearning fulfilled with the just recognition and tribute to the person of Ricarte Soto for his struggle, and until the last day of his life, his efforts to make visible and activate society around the reality of people suffering from diseases with high costs for diagnosis and treatment"(57)

*The quotes included in this column are translated from Spanish.

Table 4. How values were used in each embedded decision in Colombia

Decision	Values identified	Explanation of how the values were used	Example
Declaration of health as a fundamental right	Goals-related values: • Equality • Equity • Fairness • Quality • Right to health • Universality	**To frame health-system issues in meaningful ways for stakeholders and citizens** (60,61,106) • Stakeholders and politicians framed the problems as the lack of these goals-related values to highlight the relevance of the problems and the importance of addressing them.	Equality and fairness • Not unifying of the basket of health services for all Colombian citizens resulted in significant inequality given that the benefits plan in the subsidized regime had less than half of those services and technologies covered by the contributory regime.(106) Equity • Between 2006 and 2008, the three wealthiest departments of the country, represented more than 60% of the tutelas. By contrast, the three poorest departments combined, did not represent even 1% of the tutelas.(61) Quality • After 15 years of operating the health system, the government had not accomplished the promised update of the benefits baskets (e.g., medical indications and doses were not updated or expanded).(60) Right to health • The thousands of tutelas filed regarding health claims were understood and framed by the court as a violation to the right to health and the Court ordered the executive to make appropriate decisions to guarantee the right to health for all Colombians.(60) Universality • The funds disbursed to pay for technologies and services excluded from the benefits plans were argued to have had less beneficial impact than had they been applied to expand coverage, (particularly in the subsidized

Decision	Values identified	Explanation of how the values were used	Example
			regime) or to fund crucially needed public health policies (e.g., prevention and treatment of malaria, dengue, chikungunya and other vector-borne diseases).(61)
		To guide policy development from the perspective of the guarantee to the right to health for all citizens (61,77,78) • According to the court, society does not have fine-tuned principles that agree about how to meet health needs with equity or how to decide the prioritization of the worst off when we cannot meet the needs of all. Therefore, the court based its decisions on values regarding the fairness of the decision-making process.(2)	• In the T-760 decision, the court entrenched the value of equality by ordering that the benefits plan for the contributive regime be equalized to the benefits of the subsidized scheme. This meant that the low-income population received needed health services without the need of a tutela because the health plan now automatically protected their right to health.(77,78)
	Technical values: • Efficiency • Evidence-based • Sustainability	**To achieve the goals of the health-system efficiently** (61,65,66) • The court ordered that any reform should be financially sustainable.(66) The rationale for this order was that the right to health contains an essential core that is guaranteed to all people on an immediately enforceable basis, while the non-core elements of the right are subject to progressive realization.(65)	• The court considered the fairness of the decision-making process, and request this is based on scientific evidence but also on values and preferences of different actors.(61)
	Governance values: • Enforcement of regulation • Social participation • Stewardship • Transparency	**To frame the problems as lack of stewardship and enforcement of regulation** (60,66) • Several stakeholders pointed to the lack of a conflict-resolution mechanisms that, on the one hand, could have addressed the struggles in the health system, preventing the escalation of litigation, and on the other, enforce the regulation to accomplish the goals set out in the legislation.(60,61)	• Frequently, the Superintendency of Health and the Ministry of Health were blamed for being ineffectual in chastising health insurance companies that regularly denied included health services.(60)
		To frame problem in terms of corruption (61,64,81) • Different policy initiatives coming from the executive and legislature have been perceived as corrupted by the economic interests of influential interest groups.	• Some policymakers and stakeholders pointed to an alliance among pharmaceutical companies, doctors and judges in “judicially-stimulated corruption” that led to expensive pharmaceuticals being provided to patients when cheaper alternatives existed.(61)

Decision	Values identified	Explanation of how the values were used	Example
		To improve the efficiency and performance of the health system (66,107) • For the court, the values of transparency and rationality were identified as essential to improve the performance and efficiency of the health system.(107) The court requested a "transparent rights-based rationality", where policymakers analyze whether the objective of the existing policy results in the protection of the right to health or not.	• The Court asked policymakers to openly justify the decisions on precise, concrete evidence, and to even recognize errors, harms, and barriers, and to inform the public how they will be overcome.(66)
		To gain legitimacy in the policymaking process (60,61,65,66,68,108,109) • The Court considered social participation as a value essential to legitimizing the policies of the executive. The court found the judicial intervention as a way to mobilize the political process promoting broader participation in the decision making, not only linked to particular party's interests.(66)	• To enhance legitimacy, the court recommended a number of actions focused on using social participation and increasing transparency, including the unification of the benefits plans and the immediate update of the benefits included in the new unified plan.(61,65,66,68)
	Situational values: • Dignity of life • Gradualism	**To align policy development with the ideology of the Constitutional Court** (61,66,81,110) • For the Court, the right to health was enforceable not merely to preventing imminent death but protecting the dignity of life.(61,81,110) For the Court, every health policy decision-making should be in accordance with the principle of a dignified life and guarantee the progressive improvement in healthcare provision.	• For the Court, gradualism was considered as the progressiveness in the sense of recognizing that rights are not absolute, and therefore the development and expansion of the protection of the right to health implies certain limitations on healthcare provision.(66)
Mechanism for exclusion of technologies to be funded with public resources	Goals-related values: • Right to health	**To frame health-system issues in meaningful ways for stakeholders and citizens** (85) • Stakeholders and politicians framed the problems as the lack of these goals-related values to highlight the relevance of the problems and the importance of addressing them.	• In the Statutory Law, the right to health was declared fundamental, requiring the government to finance all services prescribed by physicians except for experimental treatments, treatments provided abroad, cosmetic treatments and treatments without any proven effectiveness.(85)
	Technical values: • Effectiveness	**To guide decisions about the nature and scope of coverage** (86,87,89)	• In the discussion about the coverage of reconstructive surgery for women with breast cancer, the decision of the Court was that the need for and nature of cosmetic or

Decision	Values identified	Explanation of how the values were used	Example
	• Evidence-based • Safety • Sustainability	• In determining the nature and scope of coverage, values were used as pragmatic instruments to define the technologies and services covered.(86,87,89)	reconstructive surgery would be decided on scientific criteria and not based on the administrative or financial considerations of the insurance companies or on the patient's opinion. The court highlighted that cosmetic surgery is expressly excluded, but that reconstructive or functional surgeries are included and under the responsibility of the insurance companies.(89)
	Governance values: • Citizen engagement • Social participation • Transparency	**To prioritize which technologies and services to exclude and to improve the acceptability of the policy** (86,87,89,111,112) • Participation of patients, citizens, and health professionals into the definition of technologies and services excluded of be funded with public resources improved social perception about the transparency of the government in formulating this policy and helped citizens (principally the people negatively affected by the exclusions) to understand how decisions were made, that they were based on reasonable criteria and scientific evidence and that they tried to balance different points of view. (86,87,89)	• At the end of 2017, 75 services and technologies were nominated to be excluded and the process used to generate this nomination considered the criteria of independent high-level experts, the professional associations of the corresponding specialty, and the patients that would potentially be affected by an exclusion decision.(111,112)
	Situational values: • Dignity of life	**To align policy development with the ideology of the Constitutional Court** (61,66,81,88,110) • For the Court, the right to health was enforceable not merely in preventing imminent death but protecting the dignity of life.(61,81,110) For the Court, every health policy decision should be in accordance with this principle.	• Women with breast cancer requested that reconstructive breast surgery should not be excluded on the grounds of it being a cosmetic treatment given that it reinforces the value of a dignified life and therefore should be eligible to be funded with public resources.(88)

Appendix 1. Sources and websites consulted

Source	Website	Type of documents searched
Ministerio de Salud de Chile	http://www.minsal.cl/	1. Reports related to health system financing 2. Specific documents related to: "Plan nacional de inversiones," "Plan AUGE," "Garantías explicitas," "ISAPRES," "FONASA." 3. News releases about financing crises 4. Relevant documents referenced in 1, 2 and 3
Ministerio de Salud y Protección Social de Colombia	https://www.minsalud.gov.co/Paginas/default.aspx	1. Reports related to health system financing 2. Specific documents related to: "Plan Obligatorio de Salud-POS", "Unidad de Pago por Capitacion-UPC", "Regulación EPS", "Fosyga" 3. News releases about financing crises 4. Relevant documents referenced in 1 and 2
Instituto de Salud Pública de Chile	http://www.ispch.cl/	Documents that present decisions about programs or services included or excluded in the public sector-FONASA
Instituto Nacional de Salud de Colombia	http://www.ins.gov.co/	Documents that present decisions about programs or services included or excluded in the National Health System
Evaluación de Tecnologías Sanitarias –ETESA (Chile)	http://www.ispch.cl/asuntoscientificos/subdepto_estudios_etesa	Reports about cost-effectiveness or health technology assessments and decisions about inclusions or exclusions of the FONASA or AUGE
Instituto de Evaluación de Tecnologías en Salud –IETS (Colombia)	http://www.iets.org.co/	Reports about cost-effectiveness or health technology assessments and decisions about inclusions or exclusions of the benefits plan (POS)
Congreso de la Republica de Colombia	http://www.senado.gov.co/	Laws, act, and bills related to health system financing, "Plan Obligatorio de Salud-POS," "Unidad de Pago por Capitacion-UPC," "Regulación EPS," "Fosyga"
Congreso Visible (Colombia database of sanctioned laws and bills in the Congress agenda)	http://www.congresovisible.org/	Search in "proyectos de ley", filtered by health and social protection and type of bill. Include those related to: "Plan Obligatorio de Salud-POS," "Unidad de Pago por Capitacion-UPC," "Regulación EPS," "Fosyga," "derecho fundamental a la salud"
Biblioteca del Congreso Nacional de Chile	http://www.bcn.cl/	Search in "Ley Chile", filtered by issue Health and using the words: "Plan nacional de inversiones", "Plan AUGE", "Garantías explicitas", "ISAPRES", "FONASA"

Source	Website	Type of documents searched
Corte Constitucional de Colombia	http://www.corteconstitucional.gov.co/	Hearings about the Rule T-760 Searches in section: “Main decisions” and “tutelas” using words: “Plan Obligatorio de Salud-POS”, “EPS”, “Fosyga”, “fundamental health right”

Appendix 2: Summary of factors playing a role in agenda setting and policy development for the health-system financing decisions in Chile

Factor		Decision 1: Regime of Explicit Health Guarantees (AUGE/GES Plan)	Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)
Agenda setting	Problem	Feedback from the operation of current programs showed that: • the public system (FONASA) offered a universal health plan to its beneficiaries, but its budgetary constraints impeded timely access to quality services;(35) and • the private system provided access to a broad range of health services in a timely manner but required private payment (through insurance or out-of-pocket) and some people had to seek care in FONASA when their health plan did not cover a particular service or health condition.(35)	• The problem was principally highlighted through a focusing event, which emerged when the journalist Ricarte Soto was diagnosed with lung cancer, and emphasized the economic barriers that patients with cancer face when trying to access to needed treatment, principally to high-cost treatments not included in the AUGE Plan.(53) • The resulting discourse from the focusing event framed these barriers as problems of equity, principally regarding financial protection.
	Policies	• An inter-ministerial committee, which included representatives of the medical association, health workers' unions, and private health providers, studied and proposed legislation designed to address the problems of the health system.(35,43,100) • The proposal that was developed fit with the vision of the president and the national mood, was technically feasible and acceptable for wide sectors of stakeholders that participated in the committee.(35,39–43)	• Ricarte Soto led a social movement advocating for a policy that addresses the barriers that citizens face to access treatments for high-cost diseases.(113) • The proposal fit with the values of the public opinion and intended to solve a problem widely covered by the media and strongly supported by Chileans.(54) • The proposal did not imply a substantial investment and therefore was considered feasible.(114,115)
	Politics	• Events within government elevated the prominence of the issue on the government's agenda given that the initiative of health reform was a promise of Ricardo Lagos' presidential campaign, who acted as a policy entrepreneur for this proposal.(39,40,43,116)	• Events within government elevated the prominence of the issues because: – the social movement promoted by the journalist Ricarte Soto was echoed in the programmatic proposal of the candidate for the presidency, Michell Bachelet, who promised a fund to cover drugs associated with complex and high-cost diseases;(54) and – the Congress strongly supported the proposal as it was congruent with the national mood, enjoyed interest group support, and fit the orientations of the elected president.(117)

<table>
<tr><th colspan="2">Factor</th><th>Decision 1: Regime of Explicit Health Guarantees (AUGE/GES Plan)</th><th>Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)</th></tr>
<tr><td rowspan="2">Policy development</td><td>Institutions</td><td>Government structures
• The division of the power in branches give veto power to the congress
o The proposals for reforms to the public system easily found support in the Senate.(41,44,45) However, the proposed reforms to the ISAPRES were modified due to the rejection by right-wing parties of the creation of a Solidarity Fund that would transfer funds from private affiliates to the FONASA (118,119) (the Fund was proposed to be financed with a portion of the salary contributions of people affiliated to the private system, with the purpose of assuring healthcare coverage to the poor population).
o The President stepped in to support the reform and decided to eliminate the proposal about the Solidarity Fund to gain in the congress the political support needed for the other changes.(118)</td><td>Government structures
• The division of the power in branches give veto power to the congress
o The President Bachelet strongly supported the initiative. However, the Christian Democratic Party announced their support only if the Government eliminated the co-payment required to access the fund.
o The president accepted this change, as well as an addition specifying that the program will no longer be only for "rare" diseases, but for those that cause “an impact on the family economy.”(92)</td></tr>
<tr><td>Interests</td><td>Societal interest groups
• The medical association rejected the legislation, citing concerns regarding a possible reinforcement of neoliberal policies in the health system, threats to medical autonomy, and deepening health inequalities,(97) and these concerns in turn mobilized health workers in opposition to the bill.(120–124)
• The President participated in some meetings with the association, and his involvement resulted in a series of agreements with health workers trying to soften the most controversial aspects of the policy.(40,64)</td><td>Societal interest groups
• Patient associations presented individual cases of people who could not access high-cost treatments or who went into bankruptcy from having to pay for expensive treatments.(125)
• Patient associations participated actively in policy development, which included nominating conditions or technologies that should be covered by the fund, as well as in discussing the criteria to decide the inclusions.
• Patient participation resulted in the inclusion of 11 diseases in the Ricarte Soto Law.(93,126)
• No organizations were identified that opposed the proposal</td></tr>
</table>

Factor		Decision 1: Regime of Explicit Health Guarantees (AUGE/GES Plan)	Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)
	Ideas	Values about 'what ought to be' • The values of the AUGE plan principally related to accessibility, financial protection, quality, solidarity, and timely access (47,127) and these values are explicitly guaranteed for all FONASA and ISAPRES affiliates for a prioritized list of diseases and health conditions. • The use of the 'right to health' rhetoric in the discussion of the reforms favoured policy development given that stakeholders considered that the proposal operationalized the concept of the right to health into something concrete that has explicit values of verifiable achievement.(46) • Media coverage and campaigns were used to counteract political opposition to the reforms,(58) and were directed to convince Chileans that the reform would not jeopardize their existing entitlements from the health system.(123)	Values about 'what ought to be' • Values of accessibility, affordability, equity (principally regarding financial protection), and social justice were considered in the development of the policy.(93,128) • Media coverage was an important factor in generating Chilean support for the initiative.(53,113–115,125,126) • Social campaigns from patient associations highlighted important ideas about the need to provide healthcare based on need and not on ability to pay.(125)
	External factors	Economic change • The AUGE/GES package set out to cover 56 priority health problems, but given budgetary constraints, the government initially included 40 diseases and conditions. In 2005 the world price of copper increased (which is an important part of the Chilean economy) and allowed the expansion of the number of diseases and conditions covered by the AUGE plan as a result of more favourable public finances.(129)	Political change • The election of Michelle Bachelet as President of Chile pushed the issue forward.(55,57) • The government of Michelle Bachelet was criticized for poorly addressing a national social movement claiming a reform in the education sector. In reaction, the president pushed for the Ricarte Soto Law to try to improve her public image and recover support from citizens.(56)

Appendix 3: Summary of factors playing a role in agenda setting and policy development for the health-system financing decisions in Colombia

Factor		Decision 1: Definition of health as a fundamental right	Decision 2: Mechanism for exclusion of technologies to be funded with public resources
Agenda setting	Problem	Change in indicators showed the increasing number of tutelas claiming the right to health, with two key indicators including: • Colombia having by far the highest per capita rate of right-to-health litigation among comparable middle-income countries;(130) and • the number of tutelas filed regarding health claims having increased 300 percent from 1999 to 2008 with over 142,000 tutelas brought to the Colombian courts in 2008 alone, which declined later in 2009 and 2010, but then peaked again in 2011, reaching 105,947 cases (12 percent more than in 2010) and continued to increase to 2012.(60,61,65,81,131) The growth in tutelas was incentivized by a rule that explicitly endowed the FOSYGA with funding to reimburse private health insurance companies after they have delivered "excluded" healthcare services to the patients whose 'right to life' was at stake.(60) • In 2009, reimbursements were close to US$963 million, whereas in 2006 they were close to US$162 million.(60) • The Human Rights Ombudsman's Office and the Attorney General's Office, in separate reports, indicated that insurance companies had been "double dipping", charging patients through premiums and charging the government again through high reimbursements paid by the FOSYGA.(60,61) The appearance of the so-called "gray zones" in the benefits plans, created uncertainty about the inclusion of some services. • Even though MRI was part of the contributory regime's basket of covered services, many health insurance companies commonly refused this diagnostic test, arguing that it involved the administration of a contrast agent 'excluded' from the basket.(60) • Between 2006 and 2008, 75% of surgeries, 63% of exams, 67% of treatments, and 78% of other procedures sought through tutela, were all part	The feedback from the operation of current programs highlighted that previous definitions of benefits packages had lacked transparency and evidence-based mechanisms of prioritization. • Previous processes used for defining a benefits basket struggled with the reimbursement of services not included in the baskets. These reimbursements put at risk the sustainability of the health system and opened the door to corruption and mismanagement in the health system. Specifically, several insurance companies apparently conspired to deny services included in the benefits plan and to only provide services until patients submitted claims to the tutela at which time, if the judge granted the request, reimbursement was then requested from the public fund.(61,81,82) • In deciding whether a tutela should be granted to the plaintiff, the judges do not typically know if the technology or service demanded is a reasonable treatment, either in medical or financial terms.(60,61,80)

Factor		Decision 1: Definition of health as a fundamental right	Decision 2: Mechanism for exclusion of technologies to be funded with public resources
		of what plaintiffs had a right to receive under their respective benefits baskets coverage.(61)	
	Policies	The feedback from the operation of current programs allowed the Constitutional Court to collect all the individual cases of tutela, showing the different dimensions of violations of the right to health.(66)	The feedback from the operation of current programs led the Constitutional court to ask the executive to develop and implement a technical scientific mechanism to define those services excluded from the core of the 'right to health' through a public, collective, participatory and transparent process.(76)
	Politics	Events within the government • In the context of a lack of legitimacy of the executive power, and a lack of policy proposals from the legislative power to address the problems, the Constitutional Court used its favourable public opinion, independence from the executive and veto power to take an active role in the health policy process by mandating a decision be made by the executive.	
Policy development	**Institutions**	Government structures (veto power) • Throught its active role in the policy process and its independence from the political system, the judicial system played an important role in shaping policy by ordering the executive to make progress towards accomplishing health-system goals and complying with laws. • The broad jurisdiction of the constitutional court, which not only rules on concrete cases but also makes constitutional revisions in the abstract to all kind of laws approved by Congress,(60,66,75,76) allowed to the Court decide what policy initiatives of the government were following the orders and principles of the court.	
	Interests	Societal interest groups • Doctors associations, patients' associations, the National Ombudsman, and other stakeholders supported the protection of the right to health, and the role of tutelas, thereby pushing the Court to decide in favor of the declaration of the right to health.(60,108,109) Other interests • The health minister and the finance minister advocated for solutions that guarantee the sustainability and efficiency of the health system, opposing the declaration of the right to health as long as this would not have clear definitions of what services were covered.(60,108,109)	Societal interest groups • The nominations for exclusions came from different actors in the health system, and a list of those nominations was published on the official website of the health ministry. • The process considered the criteria of independent high-level experts, the professional associations of the corresponding specialty, and the patients that would be potentially affected by an exclusion decision.
	Ideas	Values about 'what ought to be' • In 1992, the Constitutional Court set a crucial precedent, borrowing from the jurisprudence of the German Constitutional Court, to infer the right to health from the right to life.(60) The meaning was that although not denominated as fundamental rights in the Constitution, right to health could become fundamental and enforceable by their connection to the right to life	Values about 'what ought to be' • The Constitutional Court required the executive to finance all services prescribed by physicians except in four situations: 1) experimental treatments; 2) treatments provided abroad; 3) cosmetic treatments; and 4) treatments without any proven effectiveness.(85)

<table>
<tr><th>Factor</th><th>Decision 1: Definition of health as a fundamental right</th><th>Decision 2: Mechanism for exclusion of technologies to be funded with public resources</th></tr>
<tr><td></td><td>(doctrine of connection).(61) In 2008, the Constitutional Court abandoned the doctrine of connection and decided in T-760, that the right to health was indeed fundamental. This precedent reinforced later proceeding of the Court and its support to the Statutory Law.</td><td>• For some policymakers, the Court decision left the executive with no margin to limit the benefits plan based on cost-effectiveness or other economic considerations.(86,132)</td></tr>
<tr><td>External factors</td><td colspan="2">Court decisions
• The tutela was introduced in 1991. Tutela is an informal and expedited injunction that allows individual claims for judicial protection when fundamental human rights are threatened by the state or by a third party.(60) It was used 10,732 times in 1992 in relation to the protection of the right to health, but over 130,000 times in 2001. By 2003 over half of the Colombian Constitutional Court's docket was consumed by tutelas alleging violations of rights to health care and social assistance.(65)
• Unlike ordinary litigation, the tutela eliminates most of the usual legal formalities and is a fast-track judicial procedure that does not require the involvement of lawyers.
• By tradition, Colombia has had more than 100 years of uninterrupted judicial review,(63) and this precedent has evolved toward the acceptance of judicial activism, and the involvement of the Court in the health policy process is seen as legitimate.
• Different actors in the health system are viewed as corrupt and only the Constitutional Court is recognized as a transparent and accountable institution. Different policy initiatives coming from the executive and legislative have been perceived as being corrupted by the money of interest groups. For example:
– The Colombian Congress is widely viewed as corrupt, and legislators are not really interested in pursuing national policy initiatives. In the 2006-2010 term, about one-third of all elected congressmen were investigated and over fifteen percent actually jailed for their links to paramilitary groups.(64)
– Different stakeholders and policymakers have pointed to an alliance among pharmaceutical companies, doctors, and judges in “judicially-stimulated corruption” that led to expensive pharmaceuticals being given to patients. For example, in the media it was denounced that some pharmaceutical companies had provided financial incentives to individual doctors or to private insurers to use brand-name drugs rather than generics.(61)
– Reimbursement benefitted the insurers, pharmaceutical companies (which pushed for their own products in place of cheaper generics), and in some cases those engaged in corruption in the management of the public resources.(61,81)</td></tr>
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Chapter 4. Preface

This chapter continues its focus on the health system financing of Chile and Colombia and again uses the theoretical framework presented in chapter 2 through a multiple-case embedded study design, this time with extensive key-informant interviews. The chapter qualitatively assesses how and why policymakers and stakeholders in both countries perceive the roles of values in the same health system financing decisions described in chapter 3. Kingdon's agenda setting, 3I+E, and my theoretical framework developed in chapter 2 are used to analyze the same two decisions in each country.

I conceived the study design with my supervisor, Dr. Michael G. Wilson, and I was responsible for all data collection and analysis, which took place between November 2017 and April 2018. The members of my supervisory committee each provided feedback on drafts of the chapter, which were incorporated into the paper.

Aspect	Study 1 (chapter 2)	Study 2 (chapter 3)	Study 3 (chapter 4)
Questions addressed	10) What values inform decisions about health system financing? 11) How do values inform these decisions? 12) Under what conditions values are influential?	10) What socially and politically declared values are important in making decisions about health-system financing? 11) How do values inform these decisions? 12) Under what conditions were values influential?	10) What declared and undeclared values are important in the decision-making processes about health-system financing? 11) How do values inform these decisions? 12) Why are some values incorporated in these processes?
Design	• Critical interpretive synthesis	– Multiple case embedded-design – Discourse analysis	– Multiple case embedded-design – In-depth semi-structured interviews
Scope	• Health-system financing in Latin America	• Two health-system financing policy decisions in each of Chile and Colombia	• Two health-system financing policy decisions in each of Chile and Colombia
Data source(s)	• Scholarly literature	• Policy documents and media	• Views and experiences of policymakers and stakeholders
Type of values studied	• Declared values	• Declared values	• Declared and undeclared values
Connections between studies	• Developed a framework used as an analytical tool in studies 2 and 3	• Analyzed data using the framework developed in study 1 • Identified and explained the role of declared values to inform analysis in study 3	• Analyzed data using the framework developed in study 1 • Complemented findings from study 2 about declared values with findings about undeclared values • Identified reasons for why declared values identified in study 2 were used
Substantive contributions	• Provides a new theoretical framework of how and under what conditions values influence the policy process on for health	• Provides the first analysis of how declared values have informed two health-system financing decisions in each of Chile and Colombia	• Enriches the discourse analysis presented in study 2 to provide first-hand insights from policymakers and stakeholders about which declared and undeclared values were prioritized in

	system-financing decisions in Latin America		the policy decisions and how and why they were used
Methodological contributions	• Presents an approach for the development of a theoretical framework through a critical interpretive synthesis in a nascent area of study, where the available literature is sparse and methodologically diverse	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, and provides explanation of what values influenced those decisions, as well as how they were influential •	• Illustrates the utility of the theoretical framework developed in study 1 when analyzing how values have informed four policy decisions, enriches the findings of study 2 by identifying undeclared values and interpretations of how values influence the four decisions, and provides the opportunity to explore why some values are incorporated in these policy processes
Theoretical contributions	• Identifies four categories of social and political values playing different roles in the policy development process about health system financing in Latin America, and four conditions under which values influence decision-making in this area	• Identifies what declared values influenced two policy decisions about health-system financing in Chile and Colombia and how those values played a role • Proposes that values entrenched through large structural reforms are central to shaping the many incremental changes made to health systems in subsequent years or decades	• Provides explanations of how and why some values influenced the four decisions, and proposes that policymakers only consider a small set of prioritized and often competing values to simplify the complex interplay of values influencing a particular decision

Understanding the role of values in the health policy decision-making processes about health-system financing in Chile and Colombia: A multiple-case embedded study

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Abstract

Background: Chile and Colombia are examples of Latin American countries with health systems shaped by similar neoliberal values. Reforms introduced in each country in the 1980s and 1990s led to the emergence of private for-profit insurance companies. Recently, both countries have crafted policies to regulate the participation of such insurance companies in their health systems,

but through very different mechanisms. This study asks: 1) what declared and undeclared values are important in the decision-making processes that crafted these policies? 2) how do policymakers use values in these processes? and 3) why are some values incorporated in these processes about health-system financing in Chile and Colombia?

Methods: An embedded multiple-case study design was carried out for two specific decisions in each country: 1) in Chile, the development of the Universal Plan of Explicit Entitlements -AUGE/GES- and mandating universal coverage of treatments for high-cost diseases; and 2) in Colombia, the declaration of health as a fundamental right and a mechanism to explicitly exclude technologies that cannot be publicly funded. I interviewed key informants involved in one or more of the decisions and/or in the policy analysis and policy development process that contributed to the eventual decision. Data were analyzed using a constant comparative approach guided by three frameworks -- values related to health-system financing in Latin America (developed in chapter 2), government agenda setting, and policy development -- to generate descriptive and explanatory themes.

Results: From the 40 individuals who were invited, 28 key informants participated. Several values were identified as important to the decisions, with only one undeclared value (individualism in relation to AUGE/GES plan in Chile). Among these values, a tension between two important values was identified for each decision (e.g., solidarity vs. individualism for the AUGE/GES plan in Chile; human dignity vs. sustainability for the declaration of the right to health in Colombia). Policymakers used values in the decision-making process to frame problems in meaningful ways, to guide policy development, as a pragmatic instrument to make decisions, and as a way to legitimize decisions. In Chile, values such as individualism and free choice were incorporated in

decision-making because attaining private health insurance was seen as an indicator of improved personal economic status. In Colombia, human dignity was incorporated as the core value because the Constitutional Court asserted its importance in its use of judicial activism as a check on the power of the executive and legislative branches. I also found that this smaller set of prioritized and often competing values implies that individuals simplify the complex interplay of values by prioritizing only essential values in the policy process.

Conclusion: The study of values in the policy decision-making process in Latin America is an emerging field, which makes the findings of this study a unique contribution to this particular body of knowledge.

Introduction

Values play an important role in informing policy decision-making processes in health systems. Values can be identified as guiding policy goals,(1–3) and informing choices among policy options that could be used to achieve particular goals. In decision-making about health-system financing, values such as efficiency, equity, quality, sustainability, and universality are often embedded at all stages of the policy process.(4) However, it is often not clear how values are incorporated into policy decision-making about health system issues like financing; understanding their role in decision-making processes is challenging given the wide range of values prioritized by different stakeholders and the many ways in which values can inform policy decisions.(5)

In our critical interpretive synthesis (CIS) about the role of values in policy decision-making about health-systems financing in Latin America (Chapter 2), I identified 116 values in empirical and non-empirical papers. These values inform not only the prioritization of some issues over others on a government's agenda, but also the development of policy options to address an issue, and the implementation of selected policy options. This large number of values identified in the literature is likely driven by the fact that stakeholders and policymakers use 'values' to mean different things. For example, values can be used to refer to principles, strategies, instruments, specific goals, elements of a policy and/or beliefs about the health system. This finding has also been highlighted in the study of Giacomini et al. about values in the Canadian health system,(5) and further highlights the complexity of studying how values can drive policy decisions.

Latin America has provided a vibrant context for a study of the role of values given its many recent political transformations. In the last 40 years, many countries in the region have moved from dictatorships to democracies, democratic governments have been run by right-wing, centrist and left-wing parties and there has been unequal economic growth within and across

countries. These factors have contributed to different values being prioritized in policy decision-making in each country and thefore used to shape the many efforts to reform health systems in the region.

Chile and Colombia are examples of two Latin American countries with a rich historical context for health-system financing decisions. Their health systems were shaped by similar neoliberal values in the 1980s and 1990s that led to the introduction of for-profit insurance companies.(6–9) Recently, both countries have implemented policies to regulate the participation of private insurance companies in their health systems, but through very different mechanisms.

This history of political transformations, the presence of for-profit insurance companies, and the efforts of policymakers to accomplish the goals of health systems in this specific context, provides an opportunity to inquire about: 1) what declared and undeclared values are important in the decision-making processes that crafted four particular policies? 2) how do policymakers use values in these processes? and 3) why are some values incorporated in these processes about health-system financing in Chile and Colombia?

Methods

This study employed a qualitative multiple-case embedded design (10) with two cases and two embedded units within each case. Please see the introduction section of chapter 3 for the description of and rationale for the cases selected for the study.

Given my citizenship (Colombian), and my previous knowledge of the Colombian and Chilenan health systems, I adopted a continual process of critical self-evaluation of my researcher's positionality as well as an explicit recognition that this position may affect the research process and outcome (reflexivity).(11–13)

Selection of participants and sampling

I selected participants to ensure a balance of perspectives of people involved in the policy decision-making process for each of the health-system financing decisions selected as the embedded units of analysis in Chile and Colombia. I used three criteria to define the sample frame. First, I considered the involvement in the policy decision-making process, defined as being directly involved in one or more of the decisions included in our case study and/or in the policy analysis and development process that contributed to the eventual decision. Second, I considered the type of government in Chile and Colombia. Both countries have a presidential bi-cameral regime with a separation of powers under which the state is divided into branches (the legislative, executive and judicial), each with separate and independent powers and areas of responsibility. Third, I sought a balance of perspectives of stakeholders and policymakers from the national and local level, and in favor of and opposition to the decisions. Based on this, I created a set of categories of types of roles or positions that could have been involved in the decisions. These included policymakers (i.e., from the health ministry, the health technologies assessment institutions or commissions, public health authorities and local governments; congressmen; and judges in the case of Colombia) and stakeholders (i.e., academic authorities, medical and other health professional associations, hospitals and insurance managers, and advocacy coalitions comprising the aforementioned groups). Using this categorization scheme, I developed a sample frame of participants from individuals identified through our previous knowledge of the decisions and the discourse analysis presented in chapter 3, by searching government and organizational directories for those who might have been involved in the decisions, and by asking interview participants to identify others who were involved in the decisions.(14)

I used the sample frame to select a purposive sample of participants to invite for a qualitative interview. The purposive sampling sought to achieve: 1) maximum variation to ensure a range of key informants was sampled based on their position (i.e. a mix of policymakers and stakeholders); and 2) the engagement of individuals who could offer rich insights (e.g., those who played multiple roles). I planned to interview between 12-24 participants in each country (for a total of 24-48 interviews) to ensure a breadth of perspectives across each of the policymaker and stakeholder groups (roughly 6-12 interviewees from each group in each country) and to reach thematic saturation (i.e., when no new themes emerge from the last 2-3 interviews).

Field procedures

I used an in-depth semi-structured interview approach to explore participants' views and experiences about the three objectives of our study.(15) Participants were contacted by email with follow-ups by email and then by phone call when necessary and invited to participate in a semi-structured interview of an approximate duration of 60-90 minutes. Those who agreed to participate were interviewed in-person, or by video-call when an in-person interview was not possible.

The principal investigator (CMV) performed all the interviews, using a semi-structured interview guide. To give participants background in what I meant by values, I defined values for them as "*principles, or criteria, for selecting what are good (or better, or best) among objects, actions, ways of life, and social and political institutions and structures. Values operate at the level of individuals, of institutions, and of entire societies*".(16) In addition to this definition, I provided several examples of values commonly related to health policy decision-making, including those explicitly stated in the laws that organize and regulate the health systems in Chile and Colombia. The interview guide included questions related to the general process of decision-

making about health-system financing and about each of the decisions included as embedded units. In each of these three areas, I included prompts related to each of the three questions. I iteratively revised the interview guide as needed to allow for exploration of emerging themes and to explore assumptions or statements made by other participants (see Appendix 1 for the interview guide).

Each participant was asked to review and sign an informed consent form and was asked permission to record the interview. The audio recordings and transcripts were stored on a secure password-protected laptop. Interviews were conducted, transcribed and analyzed in Spanish, and translated to English during the process of drafting the analysis of the results.

Data analysis

Athematic analysis was conducted using a constant comparative approach for each case study, using: 1) Kingdon's framework;(17) 2) the 3I+E framework ;(18) and 3) the framework developed through the critical interpretive synthesis (CIS) in Chapter 2(see a detailed description of the frameworks used in the methods section of chapter 3) .

Analysis of the data

Data were initially examined through an open coding process where the codes were reviewed by grouping themes that are similar theoretically or connected in meaning, using the three frameworks outlined above. I created a list of codes that consisted of a catalogue of themes, issues, accounts of values, and opinions that relate to the process of policy decision-making across the cases. Based on these codes, the computer program ATLAS.Ti was used to generate a series of categories arranged in a treelike structure connecting text segments grouped into separate categories of codes or ''nodes'' to further the process of axial or pattern coding to examine the association between different a priori and emergent categories. The a priori categories were

determined using Kingdon, the 3I+E framework, and our societal values framework, as the guide for the initial analysis. Then based on the initial coding and the findings of our discourse analysis in chapter 3,(19–26) additional themes were derived and used to further code the data.

Finally, I developed policy analyses in each country by: 1) identifying what values have informed the policy decision-making process about health-system financing for each of the decisions in Chile and Colombia, and to understand how and why those values were used in that specific context; 2) describing stakeholder and policymaker perspectives and insights about specific values identified in the interviews and 3) comparing how these perspectives differ.

Research ethics

Three different research ethics committees approved this study: 1) the Hamilton Integrated Research Ethics Board (Canada) (protocol #2388); 2) the ethics committee of the University Adolfo Ibáñez in Santiago de Chile (protocol #542-17); and 3) the ethics committee of the Faculty of Medicine of the University of Antioquia in Medellin (Colombia) (Protocol F-017-00). Each policymaker and stakeholder interviewed provided consent using the information and forms approved by these ethics committees.

Results

Forty stakeholders and policymakers were invited to participate in the study (twenty in each country), and a total of 28 key informant interviews were completed (nine in Chile and nineteen in Colombia). From the group of 12 individuals who were invited but did not participate, five declined, five did not reply, and two could not participate due to scheduling conflicts despite repeated attempts to find a time that worked for them. Participants fell into the following

categories, according to their current professional role: 1) policymakers (n=10); 2) managers (n=3); 3) health professionals (n=17); 4) researchers (n=11) and; 5) members of a coalition or other aforementioned group (n=9). While participants were categorized according to their current professional role, 64% (n=10) of participants fell within two or more categories. From the policymaker's category, seven participants belong to the executive branch (three in Chile), two belong to the legislative branch (both in Colombia), and one to the judicial branch (in Colombia). The proportion of policymakers interviewed was 33% for Chile and 37% for Colombia. The interviews ranged from 33-108 minutes in length, with an average duration of 55 minutes (54 minutes in Colombia, 57 minutes in Chile) (see Table 1 for a summary of participants by role and country).

In this section I provide a descriptive narrative of each of the decisions selected, identify what values were important in the decision-making processes that crafted those policies (i.e., effectiveness, free-choice, human dignity, individualism, social participation, solidarity, stewardship, and sustainability); describe how those values were used in Tables 2 and 3 (e.g., framing problems in meaningful ways, guiding the policy development process, using them as pragmatic instruments to make decisions, and using them to legitimize decisions); explain why these particular values were incorporated in the four decisions addressed; and, in the cross-country analysis, explicitly analyze each of the three questions asked in this study.

Main findings on how values are used to make decisions about health-system financing and why some values are incorporated in those decisions in Chile

Please note that while relevant to this analysis, a description of the political context of the policy decisions in Chile is provided in chapter 3 and is therefore not repeated here, which instead focuses on insights from interview participants.

First embedded decision: Universal Plan of Explicit Entitlements (AUGE/GES Plan)

In the 1990s, politicians and stakeholders continuously criticized the performance of the Chilean health system given the feedback about how the system was failing to provide timely access to needed services. According to comments made by several of the interviewees, after the dictatorship of Pinochet and the return to the democracy, the priority of the transitional governments was to recover the democratic institutions of the country and maintain good political relationships among different forces and interest groups in such a way that the political stability of Chile was achieved. According to the interviewees, the government had more urgent issues on the decision agenda and lacked the expertise needed to plan the health system. As a result, the resources (e.g., administrative capacities of the government), incentives (e.g., economic benefits to interest groups such as insurance companies, which enhanced their power and influence in the system) and learnings about the system (e.g., the importance for the middle and upper classes to be able to access a different levels of service provided by the private for-profit sector) were further entrenched after a period of minimal policy reform.

> "*We saw many times that decision-makers, in theory, belonging to the progressist parties coalition, take the wrong way in some decisions regarding the health system, decisions that tended to deepen the differences, or tended to consolidate the system as it was established." (Stakeholder 11)*

In the 1990's, values played a significant role in framing the problems of the Chilean health system and setting them on the governmental agenda. Feedback from the operation of current

programs showed a lack of affordability for needed care due to limited to no coverage for certain diseases and health conditions and higher premiums for some populations (e.g., older adults and women of child bearing age) in the privately financed system. In addition, poor quality of and lack of timely access to care in the publicly financed system was identified as a significant and persistent issue. Following the election of a new president (Ricardo Lago), the issue gained further prominence with his proposal of a health reform that would make the system more accessible, which appeared technically feasible and enjoyed public support in the aftermath of a recent election.(27)

Several factors emerged from our analysis as being critical to supporting and also potentially limiting the likelihood of developing and implementing the AUGE/GES plan. The main factors supporting its development included: 1) the commitment to the proposal by the newly elected president Lagos, who were mostly unconstrained in their executive role; 2) the lobbying of patient groups who requested the inclusion of specific diseases to the plan (which helped shaped the focus of the plan on covering specific diseases and treatments for them); 3) the use of the right to health rhetoric in the discussion of the reforms which improved the acceptability of the proposal; and 4) the alignment of the plan with the proposal of basic universalism of the World Bank (as an external factor). In contrast, three factors appeared to have played against the development of the AUGE/GES plan: 1) the need to alter strong policy legacies of the health system established by Pinochet (which meant altering existing resources and incentives to groups in the system); 2) the opposition of private insurance companies to the solidarity fund proposed by the government (given that they would lose market share and revenue); and 3) the prevailing value of Chileans that access to private insurance as an indicator of improvement in their economic status and their social mobility (meaning that an enhanced public role could be seen as limiting their achievement of

social mobility) (see Appendix 2 for a more detailed description of the main factors that led to the policy decision).

According to the interviewees, overcoming these competing factors to develop and implement the AUGE/GES Plan was achieved by careful balancing of the discordant values of free choice and individualism and the need for solidarity in the financing arrangements for the health system (see Table 2 for a description of how values were used). The contradiction between these sets of values appears when considering that payroll taxes finance both the publicly and privately financed health systems. However, the publicly financed system is available and accessible for all Chileans, but in the privately financed system, employees use their payroll contribution to pay for individual private insurance (for the affiliate and his/her family), and these resources are not shared with the publicly financed system or with those who are sicker or have lower incomes.

The explanation of why these values are influential in the policy decision-making in Chile relates to how solidarity was understood by some interviewees as the social duty of private-plan participants to share their contributions with all the Chilean population through a common fund. In constrast, the value of individualism was understood as the desire of some Chileans to belong to an elite group with access to services that differentiate them from the general population. In this scenario, insurance companies pressed to maintain the status quo, because they could continue to benefit from the profits of this scheme in which high-income, low-risk individuals pay high premiums only to cover their own healthcare needs. Some of the interviewees stated that President Lagos' proposal included a compensation solidarity fund as an attempt to reconcile these values, but this proposal lacked the political support of parties on the right of the political spectrum which,

at least in part, represented the interests of private insurers. As a result, several actors consider that the shape the reform ultimately took fell short in terms of seeking solidarity through the system.

All interviewees agreed that the decision on which diseases and services to include in the AUGE/GES plan was ultimately guided by a focus on technical values, particularly relevance/importance to achieving public health goals for the first, and effectiveness, financial sustainability, and budget availability, for the decision about what to include in the covered basket of services. However, the interviewees also highlighted that there was an important exception to this, which was that one of the first 25 diseases included in the AUGE plan was cystic fibrosis, which was not among the main causes of disease burden in Chile.

Participants explained that cystic fibrosis was included because of the influence of interests, particularly parents of children with the disease who were influential in the decision-making process which prioritized the engagement of patients and citizens. The interviewees criticized the inclusion of cystic fibrosis within the AUGE/GES conditions not because those with it (and their parents) did not deserve timely and quality treatment and protection from financial bankruptcy, but because it did not obey the rule that society had agreed. Moreover, interviewees criticized the processes allowing for the influence from interest groups to modify the technical value chosen to define AUGE/GES´s diseases.

Ultimately, interviewees indicated that this debate between technical values prioritized by policymakers and social values advocated for by civil society is an essential contradiction in the policy-development process. For some policymakers, decisions that prioritize social values advocated by civil society, led people to view the policy process as lacking accountability, credibility, and transparency, given that interest groups influence the decision. In contrast,

stakeholders and some policymakers considered that decisions only informed by technical values lack accountability, credibility, and transparency.

Second embedded decision: Fund for health coverage of high-cost diseases (Ricarte Soto Law)

The Ricarte Soto Law emerged as a response to a focusing event. When the journalist Ricarte Soto was diagnosed with lung cancer he became aware of the economic barriers that patients like him face when trying to access needed treatments, particularly high-cost treatments not included in the AUGE/GES Plan.(28) This awareness led the journalist to promote a social movement advocating for a policy that guarantees access to treatments for high-cost diseases, which subsequently garnered political support in the form of a programmatic proposal of the presidential candidate, Michell Bachelet, who promised a fund to cover drugs associated with complex and high-cost diseases.(29)

Four factors supported the development of the Ricarte Soto Law: 1) the governing party supported the initiative (i.e., it was programmatic proposal of the newly elected president); 2) the social mobilization and lobbying efforts of patient groups made highly visible requests for the coverage of specific technologies; 3) intense media coverage fostered further support among the Chilean population, which was a key factor in changing the national mood to support the initiative; and 4) the need for the newly elected president Bachelet to develop a policy that improved her public image and helped her recover support among citizens (given than in other political areas she was losing favourable public opinion). Given that the Ricarte Soto proposal did not affect the profits of insurance companies nor the public budget of the government, the proposal had little opposition. (see Appendix 2 for a description of the main factors that led to the policy decision)

According to the interviewees, the key values that underpinned the proposed policy were equity and, to a lesser extent, social participation. Equity was identified in relation to financial protection (i.e., that need and not ability to pay should determine coverage for high-cost diseases), and also in relation to access to services irrespective of type of disease (i.e., that patients with rare diseases should be able to access treatments they need in the same way that patients with more prevalent medical conditions). Social participation was identified as the other significant value in the context of the importance of being responsive to social requests for policy action to address an issue and its prioritization ultimately rewarded the government with citizen support and favorable public opinion.

Overall, most of the interviewees indicated that the focus of health policy decision-making should be on optimizing benefit to society as opposed to making decisions to solve individual cases. Accordingly, if the focus is to make decisions that benefit society, interviewees argued that technical values such as disease burden (i.e., disease prevalence and severity of the conditions), and the effectiveness and cost-effectiveness of interventions to address them should be used by policymakers and stakeholders. However, policymakers and stakeholders stated that clear technical criteria to balance differing interests in the system do not exist, which makes robust citizen engagement important to help ensure transparency and accountability in the face of competing technical and societal interests.

Analysis between embedded decisions

In the development and implementation of the AUGE/GES plan, technical values such as disease burden, effectiveness, and sustainability, were used to define the diseases and benefits baskets included in the plan. In general, this process was considered appropriate for the

interviewees, who viewed it as making the process transparent and rational. However, interviewees perceived that the consequence of the implementation of the AUGE/GES plan, was that values such as equity, financial protection and timely access were not achieved due to the exclusion of select diseases from the plan. This problem was particularly significant for "high-cost diseases," which are less prevalent, and therefore have a small chance of being included in the AUGE/GES plan. In this scenario, the social mobilization promoted by the journalist Ricarte Soto sparked wide-spread support among members of the public and, as a result, eventually the government who responded to this pressure.

Given this, president Bachelet decided to create a fund to cover technologies and procedures for patients with high-cost diseases. This decision therefore affirmed and operationalized the government's commitment to the values of equity and financial protection by guaranteeing everyone access to what they need to recover their health. This decision, given its social origin, initiated an important citizen and patient engagement process around it. However, interviewees indicated that the decision lacked technical values that guarantee the sustainability and the efficient resource allocation among potential beneficiaries.

Main findings on how values are used to make decisions about health-system financing and why some values are incorporated in those decisions in Colombia

Please note that while relevant to this analysis, a description of the political context of the policy decisions in Colombia is provided in chapter 3 and is therefore not repeated here, which instead focuses on insights from interview participants.

First embedded decision: Declaration of health as a fundamental right

Between 1999 and 2008 the number of tutelas filed regarding health claims had increased by 300%.(30) Some of these tutelas included claims for health care services "excluded" from the benefits plans of each regime. However, most of the claims were to enforce coverage for technologies and services already included in benefits plans that health insurance companies unlawfully denied.(30,31) Most of these tutelas were granted to the plaintiffs, which made judges the last recourse to decide which health benefits citizens are entitled. This situation and the lack of compliance with the process established in the transitional rules of the health system in 1993 for updating and equalizing the contributory and subsidized benefit plans by the year 2002, led to the active role of the Constitutional Court in policy decision-making about health-system financing. The Court, seeking to reconfigure the social values with which health policy decisions are made, mandated the right to health as the focus of decision-making about health policy in Colombia. As a result, the judicial sector was the central driving force behind the focus on upholding the right to health being prioritized on the decision agenda of the Colombian government. I provide a more in-depth overview of the main factors that led to the policy decision in Appendix 3.

In 2008, the Constitutional Court passed the Rule T-760, which ordered a series of structural changes to the health system, of which some were only a restatement of injunctions contained in the legislation.(32) For instance, the Court ordered the government to take the necessary steps to unify the two regimes of health coverage, and to update the benefits included in the new unified plan.(33,34) While the Government timidly began a process of elaborating plans and policies to comply with the orders of the Constitutional Court, the private insurance companies continued to deny services included in the benefits plans, and as consequence tutelas continued to increase between 2010-2014 to approximately 107.000 each year.(35–39)

Preceded by two failed policies developed to solve these problems in 2010 and 2011,(40) (see Figure 3 of chapter 3 for a timeline of the principal events in both embedded decisions in Colombia) the government of Juan Manuel Santos presented two bills to the Congress in 2013, which included a Statutory Law and an Ordinary Law,(40) of which only the Statutory Law was passed after changes introduced by the Constitutional Court. The Statutory Law declared health as a fundamental right and de-incentivized litigation on costly health care services by forbidding the use of public funds to reimburse cosmetic and experimental medical treatments demanded by patients.(26,30,41)

For the policymakers of the executive branch, the decision of the Constitutional Court lacked technical criteria regarding the sustainability of the health system. However, for the policymakers belonging to the judicial branch and for the stakeholders, sustainability was relegated to a factor that helps to guarantee the right to health for all (see Table 3 for a description of how values were used).

> *"The Court quickly said no, because this is an insurance model that is a tool for this [healthcare], the main issue is not to protect the insurance model, the main issue is that this insurance model is a tool for this, if the model does not work, it should be discarded, but we should not to discard the purpose, this is the issue of being clear." (Policymaker 22)*

Some of the policymakers interviewed criticized the decision of the Constitutional Court because it supported the right to health in theory but did not define the limits of that right. This meant that any request for direct or indirect health care ended up being protected by the right to health under the principle of human dignity (e.g., diapers, food, payment of salary to family caregivers, etc.), which put the financial sustainability of the health system at risk.

All interviewees emphasized the importance of placing explicit boundaries on the package of benefits to which Colombians are entitled given that the health system is unable to provide everything to everyone. Some participants pointed out that by means of tutelas and allegations, expensive technologies were being funded for low-prevalence diseases and only for citizens who could navigate the judicial system (mainly middle and upper-middle classes). Therefore, communicable and prevalent diseases in impoverished regions were not being addressed, which was highlighted as an important violation of the collective right to health at the expense of assuring individual rights to health through those seeking benefits through tutelas.

While emphasizing the importance of establishing limits to the benefits basket, participants identified five factors that made it complicated to achieve: 1) distrust of stakeholders and policymakers about the hidden interests of other stakeholders and policymakers (e.g., corruption, pursuing of additional profits); 2) difficulty in establishing social participation mechanisms (e.g., with citizens, patients, interest groups) that ensure transparency and meaningful consideration of all the interests of interested parties; 3) perception of citizens, patients and doctors that giving up benefits (from the benefits basket) is unfair in view of that private insurers and private providers are not giving up part of their profits; 4) perception that scientific evidence or technical criteria used to define the benefits baskets are tied to the interests of the medical industrial complex or that they do not consider the values and preferences of the citizens; and 5) fear that health resources will be lost through corruption and not used to cover the real needs of the population.

This mistrust among health system actors is fueled by the low level of social participation in the development and implementation of policies regarding the financing of the health system and using guiding values as ‘shields’ for engaging in meaningful deliberation. The policy legacy of power concentrated in the executive branch of government through the president meant the

government could avoid putting in place real spaces for discussion and consideration of policies that solve health system problems. Since the 1990s, social participation has been encouraged, but the government has proposed mechanisms and moments of participation that are more about communicating the decisions than participating in their development. This phenomenon has led stakeholders (and some members of Congress) to reason that a request from the executive to participate or deliberate implies a request for them to legitimize or endorse a particular course of action, and that any contradictory position is not taken into account. In addition, stakeholders also highlighted that the large number of guiding values in the Colombian health system (currently 27) are being used as a shield against having to engage in meaningful democratic development of policies. As a result, decision-makers define any policy and subsequently link one or several of these guiding values to the policy in an attempt to legitimize the lack of social participation and citizen engagement.

Second embedded decision: mechanism of exclusion of technologies to be funded with public resources

The Statutory Law mandated the executive to develop and implement a technical-scientific mechanism to define those services excluded from the core of the right to health, which would mean that patients were entitled to all technologies and services except those that are specifically excluded from the benefits plan.(26) Feedback from the operation of current programs highlighted to the Court that previous definitions of benefits packages lacked transparency and the use of evidence-based mechanisms for prioritizing what technologies should be publicly funded.(31,42) To solve this problem, the Court asked for a public, collective, participatory, and transparent technical-scientific procedure, which would consider five guiding principles for excluding

technologies and procedures from public funding. These included: 1) procedures considered cosmetic, 2) procedures or technologies considered experimental, 3) technology without scientific evidence of effectiveness, 4) technology without approval of health authorities, and 5) procedures to be provided abroad when available in Colombia.(43)

The mechanism for exclusions was developed in 2017 through Resolution 330 of the Ministry of Health.(44,45) The Ministry led the process through which it promoted that stakeholders submit technologies that should be excluded, and engaged them in deliberative meetings to decide which technologies should be prioritized for exclusion from publicly funded benefits (see Appendix 3 for a description of the main factors that led to the policy decision).

In this decision, policymakers and stakeholders identified one similar value prioritized during the agenda-setting process and policy development (i.e., financial sustainability), but they differed in the other prioritized values. For policymakers, the development of the mechanism for exclusions was informed by values such as effectiveness, financial feasibility, scientific evidence, universality, and values and preferences of citizens, while stakeholders prioritized cost containment and the profitability of different private actors as key values in the policy process. These discordant points of view about the values informing the policy process negatively affected the acceptance of the mechanism for exclusions by several stakeholders, who consider that it does not reflect the values promoted by the Constitutional Court (e.g., gradualism and human dignity). These discordant points of view also led to the erosion of policy makers' confidence in social participation processes, and their view that citizens, patients, and doctors are not ready to be involved in the policy process, and that many Colombian citizens lack understanding of what a public good like healthcare means and therefore, they are not prone to protect the resources of the system.

For several stakeholders, the mechanism for exclusions proposed by the Ministry was inadequate. Specifically, interviewees argued that the Ministry converted the guiding principles ordered by the Court into rigid technical criteria, which they saw as being contrary to the spirit of the statutory law where each case should be defined according to the value of human dignity. In contrast, policymakers viewed the issue in relation to the significant financial instability of the health system where virtually everything could be required to be publicly funded with resources from the health system.

> *"How is this interpreted in reality? Everything cosmetic is excluded?, the Court even puts a particular example, a child with prominent ears, because there was a tutela. The prominent ears do not cause any problem to the kid, the kid is healthy and can make a living, but is that other kids are bullying him, they are damaging their self-esteem, he will have emotional or psychological sequels. Is this case the same as the case of a lady who simply wants to have an augmentation mammoplasty to look better? Well, no. Those are two completely different cases, in one of them we are talking of human dignity." (Stakeholder 2)*

Overall, this distrust in the process of policy development created a barrier to carrying out the orders of the Court. For example, stakeholders rejected many policies developed by the Ministry of Health because they perceived that international organizations (e.g., WB, IMF, IDB) provided the 'recipe' for health policies and that the Ministry of Health and other governmental institutions simply adapted the 'recipe' to the context. In addtion, stakeholders opposed the policies developed by the Ministry as they viewed policymakers as traditionally only having considered options that seek to reinforce the existing private health insurance model without considering whether those policy options can potentially solve the problems on the agenda.

Analysis between embedded decisions

Political science and public policy theory recognize the legislative and executive branches as appropriate institutional structures involved in most types of policymaking.(46) However, in Colombia, both embedded decisions were driven by the judicial branch, but each under different circumstances. For the declaration of health as a fundamental right, the issue came to the government agenda through the Constitutional Court, who interpreted that the thousands of tutelas claiming health services were an important issue requiring policy action to address. For the decision of the mechanism for exclusions, the Court considered that the right to health needed boundaries to establish which technologies and services to exclude from public funding. This implied a need to move from defining what is right to health in the first decision, to defining what is not in the second decision.

For the first decision, the Court explicitly ordered the government what to do and how (i.e., in the Rule T760), but for the second decision, the Court gave the executive the role of policy development and only mandated the values that must guide that policy development. This change in approach from the Court to shape health policy has been related to a process of policy learning by the Court, which led it to take the approach of a voluntary decision that empowered the executive to accomplish its goals. Despite this shift, policymakers in the executive branch considered that the intervention of the Constitutional Court disrespected the authority of the executive and triggered an unprecedented situation where citizens demanded any technology, service, or procedure to be publicly funded (e.g., diapers, equine-assisted therapy, transport, salary for family caregivers, among others). For most of the policymakers, the value of "human dignity" that the Constitutional Court put at the center of its decision was laudable, but it did not consider the importance of the sustainability of the health system. In contrast, the Constitutional Court

argued that it considered the value of sustainability not as the goal of the health system, but rather as a means to guarantee health for all.

Cross-country analysis

The principal values identified in this study were individualism, free-choice, and solidarity in Chile; human dignity, sustainability, and stewardship in Colombia; and effectiveness and social participation in both countries. I identified individualism in Chile as the only undeclared value, as well as undeclared interpretations of values explicitly named in policy documents (i.e., the perception that social participation negatively affects the consideration of cost-effectiveness in decisions).

In general, I identified four mechanisms for how values influence policy decision-making, which include framing problems in meaningful ways, guiding the policy development process, using them as pragmatic instruments to make decisions, and using them to legitimize decisions. In Chile, I identified that values were also used as a way to ensure social mobility among citizens, and specifically to legitimize decisions that were meant to deflect attention from budget constraints (see Table 2). In Colombia, I identified that values were also used to gain legitimacy in the policy-making process in the absence of meaningful citizen participation, and to shape policies in a way that is aligned with the ideas of an influential interest group (see Table 3).

Comparing both countries and explaining why some values are incorporated in the policy-making process, I found that in the case of Chile, citizens are very attached to the values of free choice and individualism, which meant that they prioritized being able to join private plans. In contrast, while Colombia shares similar contextual and political characteristics with Chile, individualism was not mentioned in any of the interviews in Colombia. This difference may be

explained by the influence of policy legacies, given that Chileans can voluntarily join the publicly financed or privately financed health system, while in Colombia affiliation with the publicly financed and privately managed health system is compulsory for all. While individualism appeared to play no role in the two Colombian decisions studied, this value could still be relevant in Chile if another topic (e.g., prepaid medicine plans) were discussed, given that the people who commonly can afford these plans are recognized as belonging to the high-income population.

In the case of Colombia, the value of human dignity was incorporated in the policy decision-making process because of the judicial activism of the Constitutional Court. According to the interviewees, power in Colombia is concentrated in the executive branch of government (specifically, in the office of the president), which has prioritized sustainability over other values. The Court acted as a constitutional check on the decisions of the executive and legislative branches when it considered that the lack of the value of human dignity in the policy decision-making process was not living up to the branches' constitutional requirements, and therefore must be included. This situation contributed to the Constitutional Court of Colombia being recognized as one of the most powerful constitutional courts in the world,(47) while in Chile the judicial branch had no impact in the health policy decisions studied.

Discussion

Principal findings

In this multiple-case embedded study, several values were identified as important to the decisions, with only one undeclared value (individualism in relation to AUGE/GES plan in Chile). Among these values, a tension between two important values was identified for each decision (e.g., solidarity vs. individualism for the AUGE/GES plan in Chile; human dignity vs. sustainability for

the declaration of the right to health in Colombia). This smaller set of prioritized and often competing values is a stark contrast to the findings of our discourse analysis in Chapter 3 where I found that many diverse values were articulated in policy documents and the media as being important for the same decisions. This difference is more than a simple divergence in quantity, as it relates to how individuals consider values in decision-making and simplify the complex interplay of values influencing a particular decision to a few elements (values) that represent the extremes of the spectrum of points of views and policy alternatives to solve a problem. For example, the current law that organizes the health system of Colombia has 27 guiding values, which are impossible to address in each policy decision. Instead, policymakers and stakeholders make decisions about how a policy can be used to achieve goals related to one particular value (regardless of whether it is explicitly declared as a prioritized value in policy documents or in the media) and ignore others. I suggest that this process of dichotomizing values in tension in decision-making processes facilitates stakeholders and policymakers to identify and prioritize essential values in the policy process, which explain why a small set of values are indeed, incorporated in the decisions.

Another principal finding of this study is that policymakers in Chile and Colombia used values in the decision-making process to frame problems in meaningful ways, to guide policy development, as a pragmatic instrument to make decisions, and as a way to legitimize decisions.

Regarding to why some values are incorporated in the policy making process. I found that in Chile, policy legacies (the voluntariness of joining the publicly financed or privately financed health system) and values of citizens (the privately financed health system is considered a benchmark of social mobility) explain why individualism, free choice and solidarity became important in the AUGE/GES plan. In contrast, in Colombia I found that values aligned with the

ideology of the Constitutional Court became influential in health policy decision-making. Despite Chile and Colombia sharing similar political and economic contexts, there is significant judicial activism in Colombia, but not in Chile. While participants in our study did not provide explicit explanations for this difference, our analysis of the decisions in Chile revealed a more pluralist approach to agenda setting and policy development, while in Colombia policy decision-making was influenced by few factors other than the president. I hypothesize that this circumstance facilitated and legitimized the judicial activism in the two policy decisions given that the Constitutional Court has intervened as a constitutional check on the power of the executive branch/president to spur action towards policy development in areas where existing health policy has been viewed as not living up to constitutional requirements. This finding is similar to what Landau suggests as an explanation for the strong influence of the Constitutional Court in Colombia.(47) According to Landau, the Court has responded to the instability of the political parties, poor social participation, and the weakness of the Congress in proposing policies and checking presidential power.(47) Moreover, according to Landau and Hawkins & Alvarez-Rosete, the strong role of the judiciary branch is a signal of new or weak democracies, and in all cases, this kind of legislative substitution is inappropriate for the policy decision-making.(46,47)

Strengths and limitations of the study

There were two main strengths of the study. First, the multiple-case embedded design allowed for an in-depth analysis of how and why values have informed the policy decision-making about health-system financing in Chile and Colombia. This was made possible through an analysis of four significant decisions (two in each country), that were made at different times, in different countries and different contexts, which allowed for an in-depth comparative analysis of how and

why values are used in policy decision-making. Second, our purposive selection of participants allowed for the inclusion of a broad range of perspectives from people involved in the policymaking process for health-system financing in Chile and Colombia. As described in the cross-country analysis, this allowed us to identify important values involved in the decisions independently of whether the interviewees supported the decision or the values that informed it, which provided rich insight into how stakeholders and policymakers understand those values.

The main challenge of this study was related to the number and composition of the sampling of participants. In Colombia, I had twice the number of interviews than in Chile, which was partially driven by us inviting more participants to engage a broader array of people with different ideological positions and professional backgrounds given the significant polarization of the perceptions about the health system in Colombia. In Chile, the agreement between different views of the health system and the values that inform the decisions were greater and, as a result, I reached saturation with fewer participants. An additional explanation for the difference in the number of participants needed to reach saturation in each country, is related to the fact that most of the participants in Colombia knew the ideas and ideological position of the interviewer, and therefore participants in Colombia spoke with less candour during the interviews, while in Chile, participants were more open and frank in their answers. To address any potential threats to the credibility of the findings due to this situation, a reflexive approach was adopted throughout all stages of the study. For example, during the interviews, this involved being self-reflective to identify questions and content that may be influenced by personal knowledge or opinions and ensuring that reactions or ways of asking questions were no provided in way that may have influenced participants opinions or responses. During data analysis and reporting reflexivity

involved being alert to 'unconscious editing' because of my own opinions and enabling fuller engagement with the data and more in-depth comprehensive analysis of it.

The other difference that accounts for the imbalance in participants from each country is that in Colombia I interviewed policymakers belonging to the judiciary, legislative, and executive branches, while in Chile I only interviewed policymakers from the executive. The principal reasons for this are that the judiciary branch is not involved in the health policy decision-making in Chile and that during the fieldwork for this study Chile was in an electoral period and, as a result, it was not possible to conduct an interview with a member of congress during that period of time. This limitation was minimized through data collection in the discourse analysis (chapter 3), where I analyzed all the media coverage about these decisions, as well as the transcriptions of public debates about AUGE/GES plan in the Chilean Congress. I did not identify a divergence between the statements of members of Congress in those hearings and the insights of policymakers participating in this case study.

Implications for policy and practice

The substantive findings of this study are important primarily for stakeholders and policymakers. For stakeholders, the findings provide analysis about the values related to the decisions discussed that support the understanding of how particular proposals or initiatives should align with the national mood to influence the decision-making. For policymakers, the findings present different points of view about how technical, social, and political values are important to designing policies that meet the needs of the population and responding to citizens' preferences. Potentially, this study could help stakeholders and policymakers in other Latin American countries or other low-and-middle income countries in the world. For example, those countries confronted

with discussions about the incorporation of values in policy decision-making processes, or in the development of policies to guarantee the right to health, might find the experiences of Chile and Colombia as a useful source of policy learning by comparing and contrasting to their situation.

Implications for future research

In Latin America, the identification of values in the policy decision-making process is an emerging field. Findings from this study can help to compare and contrast experiences about how values are used, not only in other policy domains in the Chilean and Colombian health systems, but also in other domains in social systems, such as education, social security, or child policy. Additionally, the framework of values developed in Chapter 2 and used as an analytical framework in this study, is adaptable to be similarly used in analyses of other fields and in different jurisdictions. Moreover, this study can serve as the basis for following how values are being used to implement the decisions analyzed here, or to determine if governments have changed the path of action in a different direction by prioritizing different sets of values according to specific situational factors.

This study is also directly linked to the discourse analysis of Chapter 3, which was focused on identifying declared values and how they have informed each of the embedded decisions studied. In this study, I explored the perceptions of stakeholders and policymakers about those values declared in the official documents, as well as undeclared values that were central to decision-making processes. The comparison of the values that emerged in both studies might help to understand how and why values explicitly declared are indeed incorporated in the policymaking process, under which circumstances undeclared values are more, less or equally important in the policy process, and why some values are prioritized over others in specific decisions.

Lastly, an additional field of inquiry was identified when analyzing the role of the judiciary system in the health policymaking. This represents a significant gap in our understanding of how and under which conditions, the judiciary branch plays a meaningful role in health policy decision making.

Conclusions

The study of values in the policy decision-making process in Latin America is an emerging field. Our effort to analyze health system financing policies in Chile and Colombia using political rationale frameworks and considering the influence of societal values is a unique contribution to the body of knowledge in this field. It is an opportunity open to exploring the role of values in different health decisions, political sectors besides health, and even other jurisdictions.

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Figure 1. Overview of multiple case embedded design

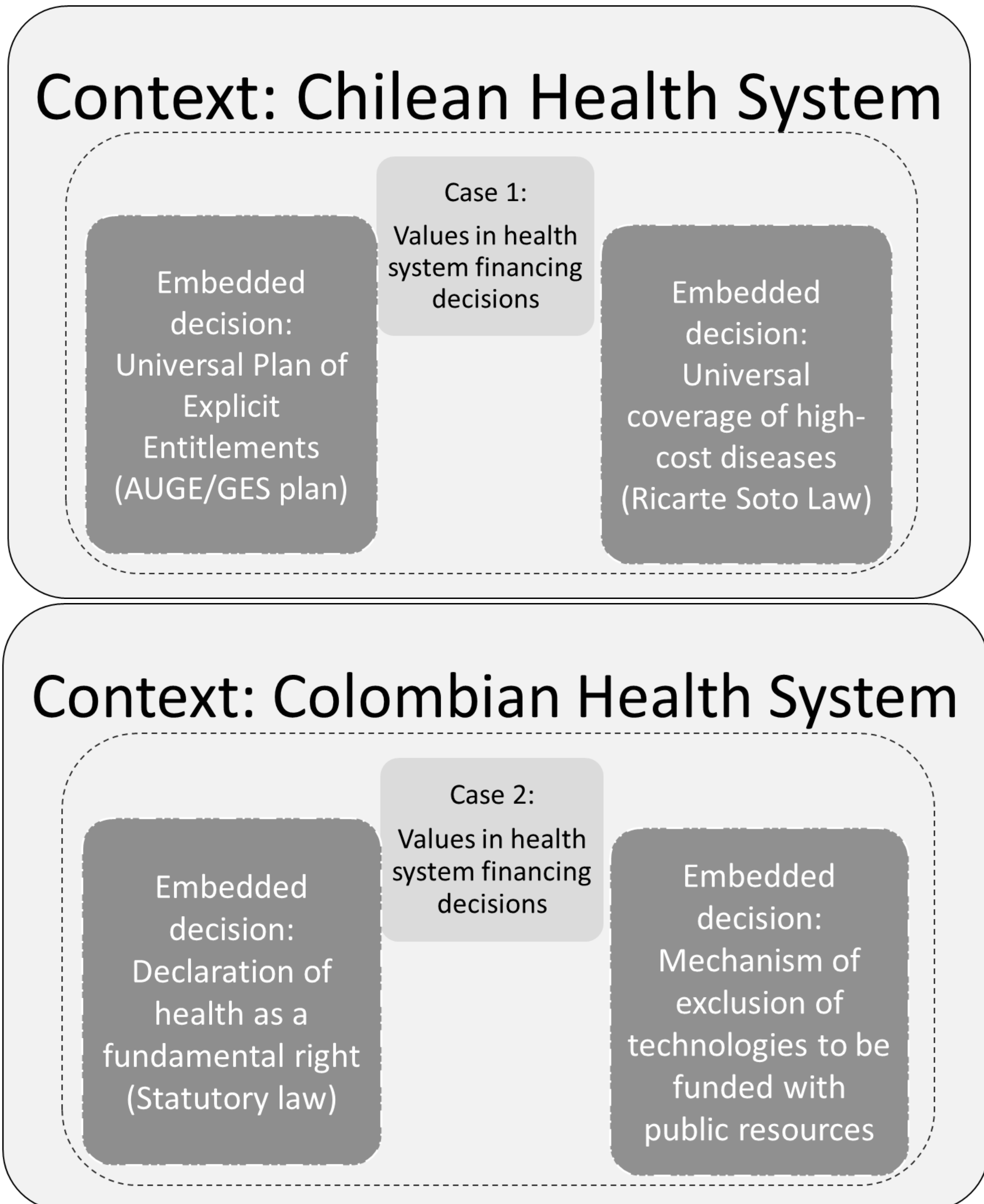

Figure 2. Timeline of the principal events in both embedded decisions in Chile

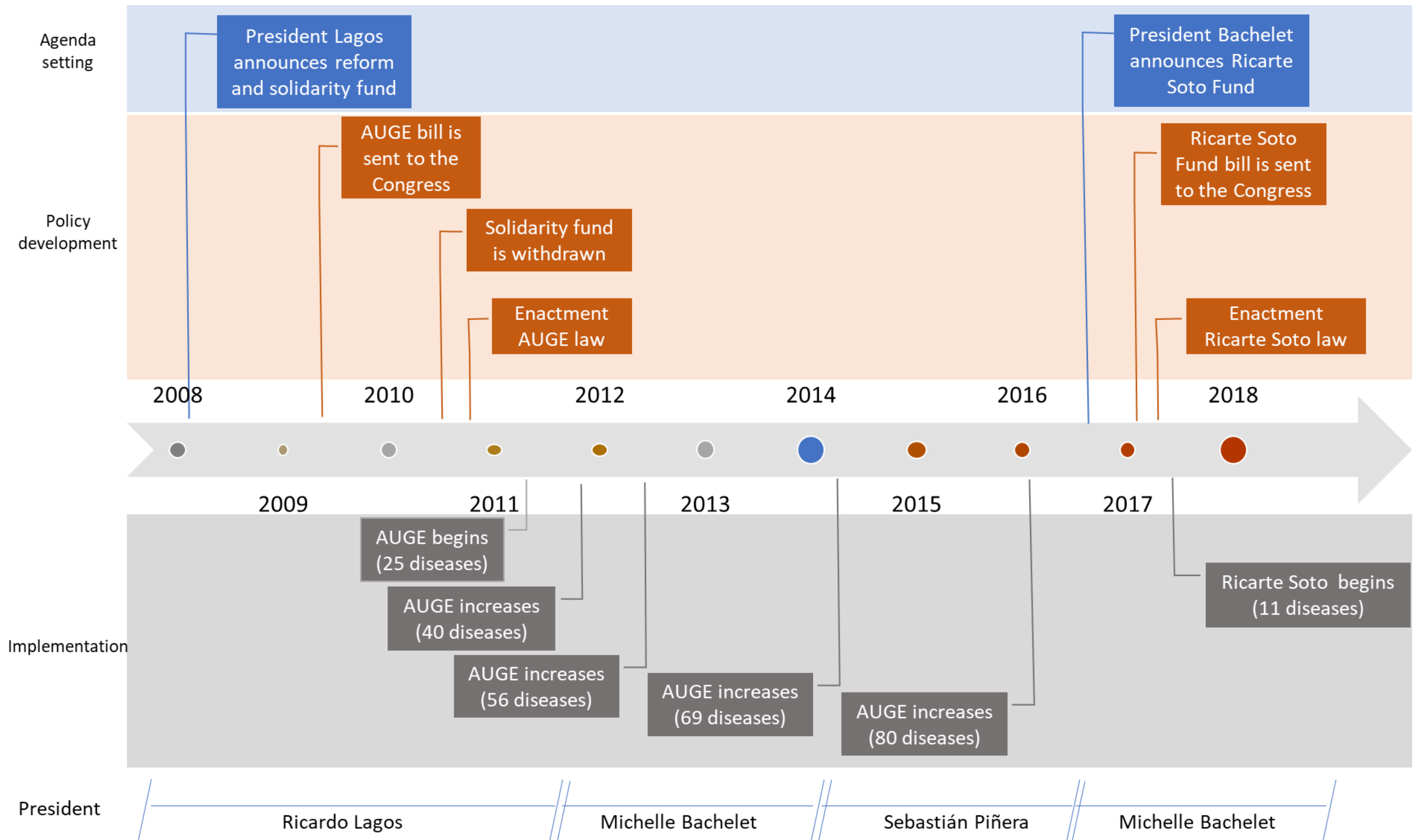

Figure 3. Timeline of the principal events in both embedded decisions in Colombia

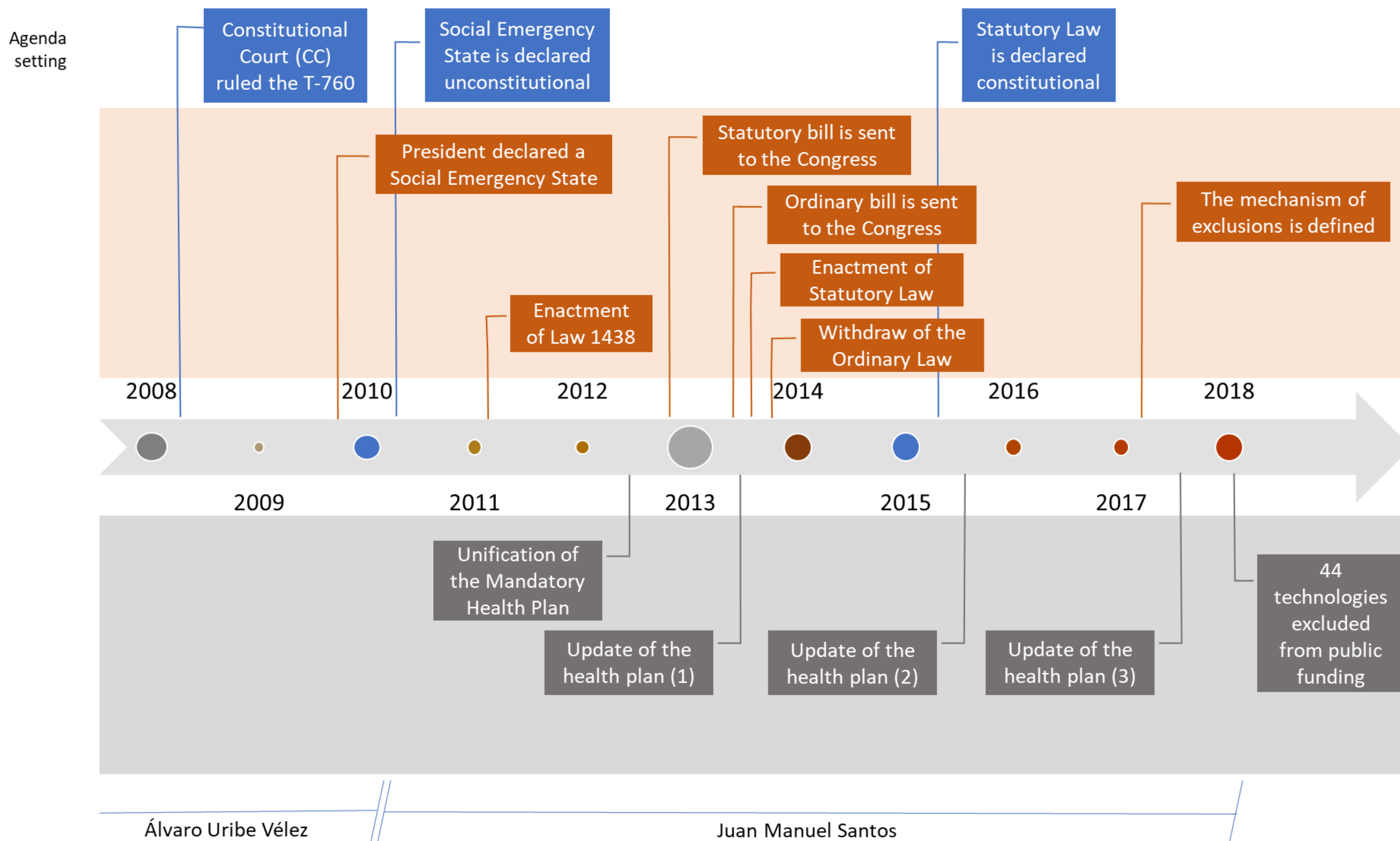
Agenda setting
Constitutional Court (CC) ruled the T-760
Social Emergency State is declared unconstitutional
Statutory Law is declared constitutional
President declared a Social Emergency State
Statutory bill is sent to the Congress
Ordinary bill is sent to the Congress
Enactment of Statutory Law
Withdraw of the Ordinary Law
Enactment of Law 1438
The mechanism of exclusions is defined
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Unification of the Mandatory Health Plan
Update of the health plan (1)
Update of the health plan (2)
Update of the health plan (3)
44 technologies excluded from public funding
Álvaro Uribe Vélez
Juan Manuel Santos

Table 1: Summary of participants by role and country

Type of participant	Chile			Colombia		
	All	Involved in decision 1	Involved in decision 2	All	Involved in decision 1	Involved in decision 2
All participants	9	9	7	19	18	15
Policymaker	3	3	2	7	7	7
Executive branch	3	3	2	4	4	4
Legislative branch	0	0	0	2	2	2
Judicial branch	0	0	0	1	1	1
Manager	1	1	1	3	3	3
Health professional	6	6	4	11	11	8
Member of a coalition or stakeholder group	2	2	2	7	7	4
Researcher	6	6	5	6	6	6

Table 2. How values were used in each embedded decision in Chile

Values identified	Explanation of how the values were used
Decision 1 - Regime of Explicit Health Guarantees (AUGE/GES Plan)	
Goals-related values • Accessibility • Quality • Solidarity • Timely access	**To frame the problems of the health systems in meaningful ways for stakeholders and citizens** Accessibility • Lack of coverage of certain diseases and health conditions in the private system, higher premiums for some populations in the private system (e.g., the eldest, women of childbearing age) Quality and timely access • Poor quality of public providers (which are the main provider in the FONASA system), and issues of timely access in the public system. Solidarity • Payroll taxes finance both public and private health systems in Chile. However, the public system is available and accessible for all Chileans, but in the private system, employees use their payroll contribution to pay for individual private insurance (for the affiliate and his/her family), and these resources are not shared with the public system, neither with those who are sicker or have lower incomes. o *"But of course, if this guy is here [the private system], but tomorrow, the basic conditions for which he was there fail, and he came down, there was a network down there, as in the circus, then he fell off the trapeze, and fell on this basic network, which is the public system, which is your last-term insurance." (Stakeholder 11)*
	To guide policy development from the perspective of an enforceable right to health • The right to Health underpinned the specific goals-related values that guided the development of the AUGE/GES plan. Those goals were: 1) an enforceable right to health; 2) the definition of treatment protocols and specific interventions necessary for treating the medical condition [quality]; 3) the adoption of maximum waiting times for each condition [timely access]; 4) the adoption of limits on out-of-pocket spending (OOPS) according to the family's income [accessibility]; and 5) the creation of a solidary fund to finance the public system [solidarity]. o *" So, we recognize, first of all, that GES is a mechanism to make explicit the right to health, and therefore, it also makes explicit what is not guaranteed. So what was taken as philosophy was to say: you know what? we are going to make the right to health explicit, that is, we are not going to say that people have the right to health in generic terms and then we see what happens, but we are going to say what people are entitled to, and what is legally required, this means, legally established and enforceable." (Stakeholder 11)*
Technical values • Effectiveness • Evidence-based • Financial protection • Rationality • Relevance/importance to public health goals	**Pragmatic instruments to develop the policy and decide which diseases and conditions should be included** • All interviewees agreed that the decision on which diseases and services to include in the AUGE/GES plan was informed by technical values, mainly considering effectiveness and relevance/importance to public health goals • However, the interviewees also highlighted that there was an exception to this rule, which was that one of the initial 25 diseases included in the AUGE plan was cystic fibrosis, which was not among the main causes of disease burden in Chile. **Pragmatic instruments to define the baskets of services that are funded for each condition included** • The definition of the benefits basket for each disease that can be funded, either with public resources in FONASA or with premiums in the ISAPRES, depended on a combination of clinical effectiveness and budgetary limitations to cover clinically effective services. **To legitimize decisions that were meant to deflect attention from budget constraints**

Values identified	Explanation of how the values were used
• Rationing	• In defining what was included and excluded from the baskets of services, the value of rationing was weighted more than the value of rationality and, as a result, stakeholders perceived that the creation of some baskets of services lacked common sense and hid budget constraints. (Stakeholders 11&12 and Policymaker 14) o *"We said Ok cataract, let's operate on cataracts, but we said let's operate only on one eye. But how? if there is an X percent who has bilateral cataracts, why are we going to operate on one eye and not the other? ... At that time the story was like this, it is better to have a one-eyed man than a blind man, there's no money for everything, so it is better to have a one-eyed man than a blind man, we are going to operate on one eye, and is very clear." (Stakeholder 12)*
Governance values • Accountability • Social participation • Transparency	**To legitimize the policy development process** • Participation of patients and citizens in the process of deciding on the conditions to be included in the AUGE plan improved the social perception about the capacity of the government to respond to social needs. • However, participation of patients and citizens also appeared to reduce the credibility and transparency of the process as a result of the seemingly disproportionate influence of some groups such as parents of children with cystic fibrosis. o For example, interviewees criticized that cystic fibrosis should not have been included within the AUGE conditions because it did not meet the rule of burden of disease that society had agreed upon. o Interviewees were critical of the process having allowed the influences from interest groups to modify the technical values that had been agreed up to define the diseases included in the AUGE/GES plan. For most of the interviewees, the focus of health policy decision-making should be on the benefit of the society as a collective, rather than making decisions to solve individual cases. o The tension between pre-defined technical values and social values articulated by civil society that at times contradicted and overrode the technical values was seen by some as reducing the accountability, credibility, and transparency of the policy-development process, while others viewed this as enhancing these factors. o Ultimately policymakers and stakeholders seem less clear about the technical values necessary to balance those interests and consider different social requests. At this point, the stock of technical criteria used to make the policy process accountable, governable and transparent, seems depleted. o *"And that is what happens with the Holocaust phenomenon, when you see the film, and you focus on a case where a child is murdered; the pain, we all fall tears. But you know that millions died, and when you know that millions died, it's like the pain diminishes. It is a psychological phenomenon. But you cannot ask that to a normative body, a normative body is supposed to feel 10 times the pain when there are 10 cases, or 100 times or a thousand times, that is the difference between the normative and the emotional descriptive. So, what is happening here is that there is a value in positioning this index case. Then, you put a child with cystic fibrosis in the media, and it appears, it is in the minds of all individuals in the society, and then cystic fibrosis has to be, and you generate and occupy that psychological mechanism, and that psychological mechanism enters into the agenda and has an effect on society. Moreover, that happens because there is not a structured normative body filtering that, that allows putting that in the balance with other things, where there is probably more pain, in sum. What's the name of that social value? I do not know how it's called." (Stakeholder 12)*
Situational values • Free-choice • Individuality	**As a way to ensure social mobility among citizens** • Several Chileans consider the health insurance as a market (private) good that can only be accessed through an individual's purchasing power. Even affiliates in the public sector do not clearly understand how FONASA works and think that each person has individual savings for health that accumulates if they do not get sick and that they should be refunded if it is not spent.

Values identified	Explanation of how the values were used
	• Several interviewees stated that Chileans give importance to the free-choice of joining the private sector, because an improvement in their economic status that makes them eligible to belong to the private health system is an indicator of social mobility. ○ *"Then, you have a society like this. Suddenly one of the trapezes falls, and suddenly we see some of those who are here [down] who improve the conditions; guess what they do? He quickly moves here [for the private one]. Why? Because he escapes the vices and complications of the public system, which are typical, the waiting list, the deal, and that ... somehow, let's say, his change of social status has attached the sticker: I´m in ISAPRE, this is part of his social repositioning." (Stakeholder 11)*
Decision 2 - Fund for health coverage of high-cost diseases (Ricarte Soto Law)	
Goals-related values • Equity	**To frame the problem in meaningful ways for stakeholders and citizens** • The journalist Ricarte Soto framed the problem of the lack of coverage of treatments for high-cots diseases as an equity problem, and highlighted that patients in the private system had timely access to those technologies but patients in the public system faced several barriers.
Technical values • Effectiveness • Financial protection • Safety	**Pragmatic instruments to develop the policy, decide which diseases and conditions should be included and to define the technologies and services covered** • The criteria to decide which diseases were included in the Ricarte Soto Fund was the financial impact that treatments caused to families. To decide which technologies to cover with the fund, the criteria was the effectiveness and safety of the interventions. Given that the treatments are high-cost, values such as cost-effectiveness or disease burden were not prioritized in making this decision. ○ *"I strongly would say that financial protection. The fact that nobody can die for not having a way to pay for her high-cost treatment, regardless of whether it was rare or not rare diseases. That was the strongest concept, and that is why the central proposal was to create a drug fund. It translated into what do we do as a country to protect these people from having their lives go to ruin by having to pay for these expensive medicines? Moreover, hand in hand, those who are most affected, that are the poorest, the middle class, and therefore the proposal had a content of equity, then it is like a mixture between both, and from that citizen´s feeling was that the public policy born in this government." (Policymaker 17)*
Governance values: • Accountability • Citizen engagement • Social participation • Transparency	**To prioritize which conditions and technologies to include** • The participation of different patients' groups in the process of prioritization implied discussions among those participants and the policymakers to decide which conditions and technologies would be funded with the Ricarte Soto Law. **To improve the acceptability of the policy** • Participation of patients and citizens in defining the conditions included in the Ricarte Soto Fund improved the social perception about the capacity of the government of giving answers to the social needs. • However, policymakers and stakeholders stated that there are no clear technical criteria to balance those interests and consider different social requests, to make the policy process transparent and accountable.

Table 3. How values were used in each embedded decision in Colombia

Values identified	Explanation of how the values were used
Decision 1 - Declaration of health as a fundamental right	

Goals-related values
• Equality
• Quality
• Right to health
• Universality
	To frame the problems of the health system in meaningful ways for stakeholders and citizens
	Equality
	• The lack of accomplishment of the gradual unification of the basket of health services for all Colombian citizens resulted in growing recognition that additional action was required.
	• Expensive technologies funded for low-prevalence diseases and only for citizens who can navigate in the judicial system (mainly middle and upper-middle classes) result in communicable and prevalent diseases in impoverished regions are not supported by the system, which resulted in the recognition that the collective right to health was not ensured.
	Quality and Universality
	• After 15 years of operating the current health system, the government had not been able to achieve a meaningful update to the benefits baskets. This was framed as lack of progress towards achieving universality and poor quality, given that clinically effective technologies were not included in the benefits baskets.
	Right to health
	• The Constitutional Court inferred the right to health from the right to life (doctrine of connection). The meaning was that although not declared? as fundamental rights in the Constitution, right to health could become fundamental and enforceable by its connection to the right to life.
	  o *"But when the Court realized that there were many concrete cases in which the principle that the court believed was the first or of value, was disregarded, then it said, all this is bad, it is no longer this concrete case, it is all the system, all is wrong, is not working." (Stakeholder 16)*
	Value-based framing of problems shape viable solutions to achieve desired goals
	• The problem was primarily framed in relation to the lack of stability and financial sustainability of the Colombian health system, as well as an overburdened judicial sector from the significant increase in tutelas, which ultimately exposed the more general flaw in achieving the protected value of the right to health in Colombia.
	• Within this framing, two sets of policy options emerged which focused on reducing the number of tutelas by:
	  1) controlling what is requested by doctors and monitoring, auditing and regulating the payments of reimbursements due to tutelas (informed by values of sustainability, protection of the state resources, and the enforcement of regulation); and
	  2) protecting the right to health, updating the baskets of benefits, and ensuring appropriate healthcare delivery to citizens (based on values such as accessibility, continuity of health care, integrality, equity and 'human dignity' as it relates to the judicial branch)

Technical values • Efficiency • Evidence-based • Sustainability	**To achieve the goals of the health system with efficiency and sustainability** • The Constitutional Court considered technical values as necessary instruments to achieve the right to health and assurance of human dignity. o *"I think we have to tune the two, what is important is that sustainability is not an end in itself, it is an aim precisely to achieve the protection of rights, and it has to be taken very seriously and not be regarded as a general argument. As we know resources are missing, as we know there are these limitations, then proceed; it has to be specific." (Policymaker 22)*

Values identified	Explanation of how the values were used
Governance values • Enforcement of regulation • Social participation • Stewardship • Transparency	**To frame the problems as lack of stewardship, enforcement of regulation and corruption** • Several stakeholders pointed to the lack of conflict resolution mechanisms that could address the struggles in the health system by preventing the escalation of litigation and enforcing regulations designed to implement the legislation for the health system. • Many interviewees highlighted that the establishment of limits to the benefits basket is a complicated decision and susceptible to corruption given five circumstances: 1) the distrust of the actors and whether they are pursuing legitimate interests; 2) the difficulty in establishing social participation mechanisms that assure transparency and real consideration of all the interests of interested parties; 3) the presence of insurers and private providers in the system causing citizens to refuse to give up their benefits while the private actors continue making profits; 4) the perception that the scientific evidence or technical criteria used to define the benefits baskets are tied to the interests of the medical industrial complex or that they do not consider the values and preferences of the citizens; and 5) the fear that health resources will be lost as result of the corruption, and therefore will not cover the real needs of the population. **To gain legitimacy in the policy-making process in the absence of meaningful citizen participation** • Stakeholders highlighted that the large number of guiding values of the Colombian health system (currently 27) meant that decision-makers can easily define policies in relation to one or more of these goals thereby gaining legitimacy without meaningful engagement of citizens. ○ *"You see that Chile has some very specific ones [values], very well defined, but in Colombia, you do not see that, you see the desire to include and include principles ... and that, at the moment of the truth, is not practical for Colombia. When you start looking, you can use anything, because the principle is there, whatever you want, you can do it because the principle is there, there are so many, that anything can be useful, whatever you want will serve anybody. I think it's the big mistake that Colombia has. It is easy, you first do and then look what value fits, it's the same when you set 80 goals, you can do anything that you want because it will point you to any goal. What you set can work accordingly for any goal." (Stakeholder 28)*
Situational values • Gradualism • Human dignity	**To shape policy development in a way that is aligned with the ideas of an influential interest group** • The Constitutional Court has given priority to the value of gradualism and human dignity. Gradualism has been defined as the progressiveness in the development and expansion of the protection of the right to health. Human dignity has been understood as the right to health care that allows an individual the physical and psychological integrity and empowerment. Those values have shaped health policy in a way that requires that it must always result in more services and technologies funded with public resources, and more people covered with those benefits. ○ *"It was reasonable that the benefits were full for those contributing for themselves and others, and that, after a time, when the sustainability of the system allowed, then, the benefits would be equal for all. That is reasonable, it is reasonable to restrict equality and equity for a time for reasons of sustainability, in order to reach equality, there is when this makes sense. Moreover, that is the way to harmonize them, but not as an irresponsible way of thinking that I can protect rights without any kind of economic reality and so on. Or the opposite, that it is an end in itself, and forgetting that this sustainability is being pursued to reach all people with equality and dignity." (Policymaker 22)*
Decision 2 - Mechanism of exclusion of technologies to be funded with public resources	
Goals-related values • Equity • Right to health	**To frame the problem as a meaningful social concept for stakeholders and citizens** • Expensive technologies funded for low-prevalence diseases and only for citizens who can navigate in the judicial system (mainly middle and upper-middle classes) result in communicable and prevalent diseases in impoverished regions that are not supported by the system, which resulted in the recognition that the collective right to health was not ensured.

Values identified	Explanation of how the values were used
Technical values • Cost-containment • Effectiveness • Evidence-based • Safety • Sustainability	**Influence the government agenda because the economic stability of the health system was at risk** • According to policymakers, the Statutory Law practically ordered public funding for all technologies and services, risking the stability of the health system. This resulted in the need for a mechanism of exclusions in order to be able to also ensure the value of sustainability. **As pragmatic instruments to define the technologies and services covered** • A key example of how values were used as pragmatic instruments was in the discussion about the coverage of reconstructive surgery for women with breast cancer as the decision of the Court was that the nature of cosmetic or reconstructive surgery would be decided on scientific criteria and not supported by administrative or financial considerations of the insurance companies or the patient's opinion. The court highlighted that cosmetic surgery is expressly excluded, while reconstructive or functional surgeries are understood to be included and under the responsibility of the insurance companies.
Governance values • Citizen engagement • Social participation • Transparency	**To improve the acceptability of the policy** • The procedure of exclusions highlighted the values of social participation and transparency with the rationale that these values can help to the citizens, principally the people negatively affected by the exclusions, to understand how decisions were made and whether they were based on reasonable criteria and scientific evidence. • The government considered successful national and international experiences with social participation and citizen engagement to improve the acceptability of the policy. However, patients' organizations, health professionals, and social organizations fear that participating implies endorsement of policies with which they disagree.
Situational values • Human dignity	**To shape policy development in a way that is aligned with the ideas of an influential interest group** Patients, health professionals, and social organizations criticize the development of the mechanism of exclusions given they consider the value of human dignity was converted into rigid technical criteria. They advocate for the decisions to respect this value promoted by the court. o *"How is this interpreted in reality? Everything cosmetic is excluded? the Court even puts a particular example, a child with ears on screen, because there was a tutela. The ears on screen do not cause any problem to the kid, the kid is healthy and can make a living, but is that other kids are bullying him, they are damaging their self-esteem, he will have emotional or psychological sequels. Is this case the same as the case of a lady who simply wants to have an augmentation mammoplasty to look better? Well, no. Those are two completely different cases." (Stakeholder 2)*

Appendix 1. Summary of factors playing a role in agenda setting and policy development for both embedded decisions in Chile

Factor		Decision 1: Regime of Explicit Health Guarantees (AUGE/GES Plan)	Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)
Agenda setting	Problem	**Feedback from the operation of current programs** • Lack of affordability for needed care due to limited to no coverage for certain diseases and health conditions and higher premiums for some populations (e.g., older adults and women of child bearing age) in the private system • Poor quality of and lack of timely access to care in the public system.	**A focusing event** • The journalist Ricarte Soto when diagnosed with lung cancer, emphasized the economic barriers that patients with cancer face when trying to access needed treatments, principally to high-cost treatments not included in the AUGE Plan.
	Policies	**Diffusion of ideas and communication/persuation (from international agencies)** • The AUGE/GES proposal integrated two ideological approaches advocated for by international agencies (principally the World Bank), which included "basic universalism" prioritized by the World Bank and the rhetoric of the right to health of some stakeholders. • This combination made the proposal 1) acceptable for wide sectors of stakeholders, 2) technically feasible, and 3) fitted to the vision of the president and the national mood.	**Communication/persuasion** • Ricarte Soto led a social movement advocating for a policy that addresses the barriers that citizens face to access treatments for high-cost diseases. • The proposal fit with the dominant public values of support to the needs of patients with high cost diseases and intended to solve a problem widely covered by the media and strongly supported by Chileans.
	Politics	**Events within government** • Events within government elevated the prominence of the issue on the government's agenda given that the initiative of health reform was a promise of Ricardo Lagos' presidential campaign, who acted as a policy entrepreneur for this proposal	**Events within government** • Events within government elevated the prominence of the issue because the values that gained prominence from Ricarte Soto's social movement were: o aligned with the proposal from presidential candidate Michell Bachelet to fund drugs associated with complex and high-cost diseases, and o strongly supported by the Congress given that it was congruent with the national mood, enjoyed interest group support, and fit the orientations of the elected president.

Factor		Decision 1: Regime of Explicit Health Guarantees (AUGE/GES Plan)	Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)

Policy development	Institutions	**Government structures**
		• Right-wing parties opposed the creation of a Compensation Solidarity Fund.
		  ○ This fund was proposed to be financed with 3/7 of the salary contributions of people affiliated to the private system, with the purpose of assuring healthcare coverage to the poor population.
		• The President supported the reform and eliminated the proposal of the Solidarity Fund to gain the political support needed for the other changes.
		  ○ *"In fact, the law in its origin contemplated the solidarity fund, the common one. However, in the Congress, the majority was not obtained, and therefore, it was one of the trade-offs for the law to continue. In the end, the solidarity fund was withdrawn so that the law could move forward."* (Policymaker 17)
		Policy legacies
		• Policy decisions about the health system have continually reinforced the model implemented during Pinochet's dictatorship.
			Government structures
			• President Bachelet strongly supported the initiative, which was the key factor for the Ricarte Soto Law to pass.

	Interests	**Societal interest groups**
		• Private insurance companies did not support the solidarity fund given that it affected their profits.
		• The explanation for the inclusion of cystic fibrosis in the first group of diseases covered by the AUGE/GES plan is that interest groups, specifically, parents of children with this disease were influential in the decision.
			Societal interest groups
			• Patient associations:
			  ○ presented individual cases of people who could not access high-cost treatments or who went into bankruptcy from having to pay for expensive treatments;(48)
			  ○ participated actively in policy development (e.g., by nominating conditions or technologies to be funded and reviewing criteria to decide what to fund); and
			  ○ sought support of celebrities (artists, soccer players, etc) to champion requests for technologies to be included into the Ricarte Soto fund that do not fall within the criteria of high-cost diseases (e.g., insulin infusion pumps which were eventually approved for inclusion in the fund by the government as a result of social pressure)

Factor		Decision 1: Regime of Explicit Health Guarantees (AUGE/GES Plan)	Decision 2: Fund for health coverage of high-cost diseases (Ricarte Soto Law)
	Ideas	**Values/mass opinion about 'what ought to be'** • The right to health was prominent during policy development as a result of stakeholders seeking to turn the concept into something concrete. o *"So, we recognize, first of all, that GES [AUGE/GES plan] is a mechanism to make explicit the right to health, and therefore, it also makes explicit what is not guaranteed… So, what was taken as philosophy was to say: you know what? we are going to make the right to health explicit, that is, we are not going to say that people have the right to health in generic terms and then we see what happens, but we are going to say what people are entitled to, and what is legally required, this means, legally established and enforceable." (Stakeholder 11)* • Chileans have prioritized the value of free choice, which was not supportive of the development of the solidarity fund and the unification of the public and private system o Several interviewees stated that the Chilean health system is based on a principle of free choice to which Chileans feel very attached. This implies giving importance to the possibility of joining the public or private sector, but mostly, to the value of individuality, because the hope of an improvement in their economic status (and therefore social mobility) that makes them eligible to belong to the private health system is important to Chileans. (Stakeholders 11&17 and policymaker 15)	**Values about 'what ought to be'** • Media coverage was an important factor to promote the Chilean support to the initiative, particularly social campaigns of patient associations which highlighted high-profile ideas about the need to provide healthcare based on need and not on ability to pay.
	Externa l factors	**International donors** • The AUGE/GES plan was aligned with the proposal of basic universalism of the World Bank.	**Political change** • The election of Michelle Bachelet as President of Chile pushed the issue forward.

Appendix 2. Summary of factors playing a role in agenda setting and policy development for both embedded decisions in Colombia

Factor		Decision 1: Definition of health as a fundamental right	Decision 2: Mechanism of exclusion of technologies to be funded with public resources

Agenda Setting	Problems	**Change in indicators**
		• **Increasing number of tutelas claiming the right to health**
		  o Tutelas became the preferred mechanism to have real and timely access to technologies or services that: 1) were contained in the benefit plans but were not delivered to the citizens (a problem of lack of regulation of the insurers); 2) were contained in the benefits plan of the contributory regime but not of the subsidized one (a problem of inequity); 3) were not included in the benefit plans but were requested by the treating doctor (a problem of lack of updating of the plans).
		• **The high success rate of tutelas put significant burden on the justice system and financial burden on the health system**
		  o Approximately 80% of tutelas were granted to the plaintiffs. This means mandatory compliance orders for insurers, local governments, and providers; and the economic cost of these benefits was charged in full or in a significant proportion to the public health fund -FOSYGA-, and not to the premium of the private insurer.
		  o All this background gave rise to a problem of immense proportions, thousands of tutelas claiming healthcare, cramming the offices of the judges, and a public system paying reimbursements for healthcare that in the vast majority had already been paid to insurance managers through premiums (units of payment by capitation).
			Feedback from the operation of current programs
			• **Inequity in the health system caused by health litigation**
			  o Some interviewees pointed out that by means of tutelas, the individual right to health has been prioritized over the collective right.
			  o Expensive technologies have being funded for low-prevalence diseases and only for citizens who can navigate in the judicial system (mainly middle and upper middle classes).
			  o As a result, communicable and prevalent diseases in impoverished regions, where there is an insufficient amount of health providers and where the population is less likely to demand health care, are not supported by the system thereby not ensured the collective right to health.

	Policies	**Diffusion of ideas and communication/persuasion**
		• **Two sets of policy options appeared to reduce the health litigation**
		  o First, by controlling what is requested by doctors and monitoring, auditing and regulating the payments of reimbursements due to tutelas.
			Diffusion of ideas and communication/persuasion
			• **The court asked the executive to develop a mechanism to define those services excluded from the core of the right to health**
			  o The technic-scientific mechanism must consider four criteria of exclusion. Those are: 1) the cosmetic, 2) the experimental, 3) technology without scientific evidence of effectiveness or

<table>
<tr><th colspan="2">Factor</th><th>Decision 1: Definition of health as a fundamental right</th><th>Decision 2: Mechanism of exclusion of technologies to be funded with public resources</th></tr>
<tr><td rowspan="2"></td><td></td><td>o Second, through the protection of the right to health, updating the baskets of benefits, and ensuring the appropriated healthcare delivery to the citizens.</td><td>approval of health authorities, and 4) procedures to be provided abroad when available in Colombia.
o National experts (principally economists) promoted establishing boundaries to the package of benefits to which Colombians are entitled. This proposal was presented like a logical, coherent and necessary development given that the health system is unable to provide everything to everyone at the high prices of the market.</td></tr>
<tr><td>Politi</td><td colspan="2">Events within the government
• Events within government elevated the prominence of the issue on the government's agenda given that the Constitutional Court took an active role in the health policy process by mandating a decision be made by the executive.</td></tr>
<tr><td rowspan="3">Policy development</td><td>Institutions</td><td colspan="2">Government structures (veto point)
• Within a context of political power concentrated in the executive with the president, and a weak role of the Congress in policy development, the judiciary system took an active role in shaping the health policy by ordering the executive to make progress towards accomplishing health system goals and complying with the laws.
• The broad jurisdiction of the constitutional court, who not only decides on concrete cases but also makes a constitutional revision in the abstract of all kind of laws approved by Congress, allowed to the Court to decide what policy initiatives of the government following the orders and principles of the court.
o "I am a parliamentarian of this society and not another, but I believe that legal texts, laws, the more time I pass in Congress, the less importance and value I give to them… this institution [the Congress] is so weak, here we do as the president says, that is what is done here. And whatever the Court says, they entangle, because the problem is political, and since these people have managed and run the country since ancient times, there is nothing worthwhile." (Policymaker 10)</td></tr>
<tr><td>Interests</td><td>Societal interest groups
• Doctors associations, patient's associations, the National Ombudsman, and other stakeholders supported the protections of the right to health, and the role of tutelas, pushing the Court to decide in favor of the declaration of the right to health.
• A doctors' coalition lobbied to get the president's support for the Statutory Law.
Other interests
• Private interest groups lobbied against the Statutory Law looking for ensuring economic profits.</td><td>Societal interest groups
• Doctors and patient's associations distrust the mechanism of exclusions given the presence of for-profit actors in the health system and because consider this implies endorsement of a strategy of the government to diminish the core of benefits of the right to health
o Stakeholders perceive private insurers as promoters of exclusions because in that way they limit services to affiliates and therefore obtain higher profits.
o Stakeholders perceive the pharmaceutical industry as an interest group that opposes exclusions given that they have more profits if drugs are funded with public resources of the health system.</td></tr>
<tr><td>Ideas</td><td>Knowledge/beliefs about 'what is'
• The government has only considered proposals that seek to reinforce the existing health system model</td><td>Knowledge/beliefs about 'what is'
• It is necessary to establish boundaries to the health benefits plan</td></tr>
</table>

Factor			Decision 1: Definition of health as a fundamental right	Decision 2: Mechanism of exclusion of technologies to be funded with public resources
			○ Stakeholders perceived that the executive has not considered different approaches that might solve the problems of the health system. ○ *"Because we are facing a ministry that has been fully charged towards insurance. To save the private insurance scheme they ignore the crisis; nothing has happened here, they have removed all the regulations as long as the EPS [private insurers] survive ten years more and pay the carrots." (Stakeholder 7)* • **The Constitutional Court is perceived as free of the corruption that is present in other institutions of the government** ○ All the interviewees considered the Constitutional Court as a neutral, pluralistic, and rational institution, that makes decisions balancing different perspectives and aiming the collective benefit of society. • **The presence of for-profit actors in the health system is perceived as immoral** ○ Some stakeholders considered that the existence of private insurers and for-profit private providers imprint to the model an immoral character per se, given that they actively seek profitability with public resources of the health system. The frantic search for profitability in the health system is perceived as inappropriate for a country where health is seen as a fundamental right, the needs are immense, and inequity is a structural problem of the society. **Values about 'what ought to be'** • **The right to health ceased to be enforceable given its connection to the right to life, and become fundamental by itself** ○ The Political Constitution of Colombia holds a contradiction regarding healthcare, which is considered both a right and a public service. The tutela was created as a mechanism to claim compliance with fundamental rights. However, the protection of health could not be claimed directly, because it was not clear that it was a fundamental right. As a result, the Constitutional Court decided to infer the right to health from the right to life, and then become fundamental and enforceable by the "doctrine of connection".	○ All the interviewees considered it necessary to clearly define what people are entitled to, and what is legally required and enforceable. ○ *"Everything should be covered?, there we have a strip of debate. First, what is useful and what is not, and second, I do not say this in public at this moment, but it is the discussion about the cost-benefit. Lets see an extreme case, if to save the life of an old man of 90 years there is a technology that extends his life 3 months and the price is ten billion of pesos, in that case, we have a debate." (Policymaker 4)* • **Citizens do not understand the meaning of health care as a 'common good'** ○ Policymakers perceived that Colombians do not measure the meaning or significance of the health system as a common good, and therefore they are not prone to protect the resources of the system. ○ *"We do not have a culture of what is a common good, and what happens to a common good when we over-exploit it, when we do not take care of it. I think more education is lacking in our system. Moreover, we need put the discussion about the values on the table, and that is something that people do not want to discuss." (Policymaker 9)* **Values about 'what ought to be'** • **The health system should cover the maximum of technologies** ○ Some stakeholders consider that the spirit of the statutory law is to guarantee healthcare for all, and therefore the health system should cover the maximum of technologies. They think it is necessary to change the model of private insurance to have more resources to do so. • **The criteria established by the Constitutional Court left the executive with no margin to limit the benefits plan based on cost-effectiveness or other economic considerations** ○ *"And that thing of how the law was written, it is a dream, not even the richest countries on this planet face coverage decisions*

<table>
<tr><th colspan="2">Factor</th><th>Decision 1: Definition of health as a fundamental right</th><th>Decision 2: Mechanism of exclusion of technologies to be funded with public resources</th></tr>
<tr><td></td><td></td><td>o In 2008, the Constitutional Court abandoned the doctrine of connection and decided in T-760, that the right to health was indeed fundamental. This precedent has reinforced the following proceedings of the Court and its support to the Statutory Law.
o "Very individual decisions are made, with a basic humanitarian value. Yes, I have a tragedy and I want to remedy it. But the State can not be a cosmic justice, I cannot remedy everything, I have to have a reflective discussion of what I want to do and what seems to be simply philosophical. I believe that our health system has lacked of a substantive discussion about what values ought to be, what we want to do, how far we want to take this." (Policymaker 3)</td><td>or decisions about inclussions and exclussions, with criteria like ours. Okay, let's say the cosmetic is excluded, that’s the minimum, the gluteus surgery to the lady, the breasts to the lady, maybe we do not have to pay for it, those exclusions are the minimum, the basic. No-experimental, well, that’s the minimum, we do not know if works or not, if it is going to kill or not, let's wait to see if at least get registry approval. Provided abroad, that at least we do not have to send people to Europe and the United States to get the treatments, that’s the minimum too. The lack of clinical effectiveness, is also the minimum, why do we have to pay for something that does not help at all? Then, those principles are the minimum." (Policymaker 9)</td></tr>
<tr><td></td><td>External factors</td><td colspan="2">Court decisions
• In 2008, the Constitutional Court passed the Rule T-760, which contained a series of structural changes to the health system, some of them were only a restatement of injunctions contained in the legislation
• In 2014, the Constitutional Court asked the executive to develop and implement a technical-scientific mechanism to define services excluded from the core of the right to health through a public, collective, participatory and transparent process.
Economic situation
• The weakness of the welfare state incentivized Colombians to try to solve their social and health problems through the tutela and with public resources of the health system.
o Colombia has a significant participation of the private sector in social issues such as education, public services, and health. The welfare state is insufficient to solve the high number of social needs. Therefore, Colombians come to the tutela to access services and supplies related to healthcare, such as payment of salary to family caregivers, diapers, food, transportation, among others.
o " The State as rector of the health system, ah, with a state like this little one? Here we get anything, the epidemics that we lived in Chikungunya, malaria, dengue, and Zika, and all transmitted by vectors, with an inability to operate because there is no State, no State at all. Because the State was lost in the market. "(Policymaker 10)</td></tr>
</table>

Appendix 3. Recruitment email

Subject: Invitation to participate in the study "*Understanding the role of values in the health policy decision-making process about health-system financing: Case studies of Colombia and Chile*"

Dear Sir/Madame,

You are being invited to participate in a research study to improve our understanding of how and why values inform the policy decision-making in health system financing in Colombia/Chile. For general background about this study, we have attached a project summary that outlines our study objectives and methods. Specifically, you are being invited to an interview about your views and experiences about how values inform decisions related to health-system financing in [Colombia/Chile].

Although values rise to explain the goals pursued in the health system and how they benefit the population, it is not clear how they are incorporated into the health policy decision-making process. We are conducting a study to improve our understanding about how values inform policy decision-making process about the financing of the health system. This study will take the form of an in-depth interview that allows you to share your views and experiences about how and why values inform decisions about health-system financing.

Thank you for taking the time to consider your participation in our research study. If you have questions or would like additional information, please do not hesitate to contact me. If you have any questions regarding your rights as a research participant specifically, you may contact either the [insert contact details research ethics board in Colombia or Chile] or the Office of the Chair of the Hamilton Integrated Research Ethics Board at (905) 521-2100, Ext. 42013.

Sincerely,

C. Marcela Vélez
Health Policy PhD Student
McMaster University
1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
Tel: +1 905-525-9140 ext. 22674
Email: velezcm@mcmaster.ca

Appendix 4. Letter of invitation to participate

Title of study:	Understanding the role of values in the health policy decision-making process about health-system financing: Case studies of Colombia and Chile
Principal investigators:	C. Marcela Vélez, MD, MSc and Michael G. Wilson, PhD

[Insert date]

Dear Sir/Madame,

You are being invited to participate in a research study to improve our understanding of how and why values inform the policy decision-making in health system financing in Colombia/Chile. For general background about this study, we have attached a project summary that outlines our study objectives and methods. Specifically, you are being invited to an interview about your views and experiences about how and why values inform decisions related to health-system financing in [Colombia/Chile].

It is important for you to know that you can choose not to take part in the study. The benefit to you of participating in the research study is that you can help to improve the understanding of how and why values inform decisions about health-system financing in Colombia/Chile.

Your responses to the interview questions will be considered confidential. We will ensure that the data is stored on a security-protected computer and will be destroyed six years after the last publication of our findings. Your anonymity as a research study participant will be safeguarded. We will use a unique participant number to identify your interview responses and ensure that the list of study participants and their participant numbers are stored in a different locked cabinet or security-protected computer from those where the interview responses are stored. We will not present a summary of our findings in a way that you or your organization can be identified.

Our experience with pilot-testing the interview suggests that it will take 60-90 minutes. If you feel you cannot answer a question, you can skip it and go on to the next question. The interview will take place with Marcela Vélez at a mutually convenient date, time and location. Alternatively, we can conduct the interview over the telephone at a mutually convenient date and time.

Thank you for your valuable contribution to our research study. If you have questions or would like additional information, please do not hesitate to contact me. If you have any questions regarding your rights as a research participant specifically, you may contact either the [insert contact details research

ethics board in Colombia or Chile] or the Office of the Chair of the Hamilton Integrated Research Ethics Board (at McMaster University in Canada) at +1 905-521-2100, extension 42013.

Sincerely,

C. Marcela Vélez
Health Policy PhD Student
McMaster University
1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
Tel: +1 905-525-9140 ext. 22674
Email: velezcm@mcmaster.ca

Michael G. Wilson, PhD
Assistant Professor
McMaster University
1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
Tel: +1 905-525-9140 ext. 22674
Email: wilsom2@mcmaster.ca

Appendix 5. Information sheet and consent form -McMaster University

Information sheet and consent form for interview participants

Understanding the role of values in policy decision-making process about health-system financing. Case studies of Colombia and Chile

Principal Investigator:	**Local Principal Investigator:**
Marcela Vélez	Dr. Michael Wilson
Department of Clinical Epidemiology	Department of Clinical Epidemiology & Biostatistics
McMaster University	McMaster University
1280 Main Street West Hamilton, ON, L8S 4K1	1280 Main Street West Hamilton, ON, L8S 4K1
(905) 525-9140 ext. 22952	**(905) 525-9140 ext. 22952**
E-mail: velezcm@mcmaster.ca	E-mail: wilson2@mcmaster.ca

Funding source: Student support provided to Marcela Vélez from Colciencias

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You are being invited to participate in an interview on the topic of how values inform the policy decision-making in health-system financing in Colombia/Chile. In order to decide whether you want to be a part of this initiative, you should understand what is involved and the potential risks and benefits. This information sheet provides information about the interview, which will also be discussed with you before the interview. Once you understand the purpose of this initiative, you will be asked to sign this form if you wish to participate. Please take your time in making your decision.

Purpose of the Study

The purpose of this study is to understand how and why values are used in the policy decision-making process regarding health-system financing. This research study is being conducted as part of a PhD thesis.

Your involvement

In signing this form, you agree to participate in the interview that will last approximately 60-90 minutes. According to your availability, the interview might be in-person or by phone.

We have an interview guide with several questions to prompt discussion. For example, we will be asking you questions about what values you think are most fundamental to informing policy decision-making about health system financing. Based on how the interview progresses and your answers, the exact wording of some question may change or follow-up questions may be asked. For example, we may use additional short questions to ensure we understand what you told me or if we need more information when we are talking (e.g., "So, you are saying that …?", "Please tell me more?", "Why do you think that is…?".

If you accept, we will record the interview and after we will transcribe it. We will analyze the transcription of the interview to identify themes and classify these themes and points of view according to different stages of the policy decision-making process.

Costs and benefits of taking part in this initiative

There are no physical risks involved in participating in this initiative. The main cost to you is the time you take to participate in the interview. In asking you to provide your views and experiences about the values in the health system, you may feel that you are revealing sensitive information that could negatively affect you. We have sought to minimize these risks by ensuring the complete confidentiality of your responses and by providing assurances that you may withdraw at any time from this initiative without prejudice.

If you agree to take part in this initiative, there may or may not be any direct benefit to you, but we believe that policymakers and stakeholders will directly benefit because the views and experiences of participants will improve their understanding of how and why values inform decisions in health systems. Thus, it constitutes a unique opportunity to have your voice heard. We hope that the results will be of interest to you, and they will be of great value to you and others working in the [Colombian/Chilean] health system.

We expect to complete interviews for this study from December 2016 and complete the study analysis by October 2017. If you would like a brief summary of the results, please let us know how you would like it sent to you.

Confidentiality

All data collected will be kept confidential. No one but principal investigators will know whether you were in the study unless you choose to tell them. Anonymity will be safeguarded by assigning a unique participant number to identify each person's interview and data, and ensuring that the list of participants, their contact information, and their corresponding participant numbers are stored in a different locked cabinet and security-protected computer from those where the data are stored. A summary of our findings will be presented in a way that an individual cannot be identified. All data collected will be destroyed six years after the last publication of the evaluation findings.

Voluntarism

Your participation in this interview is voluntary. If you decide to withdraw, there will be no consequences to you. If you withdraw during the study, we will cease the collection of data and you will be asked whether you would like to have the data that you have provided retained for use in the evaluation or destroyed. If you decide to withdraw after the interview, but before the final report is written, you may contact the principal investigator or the local principal investigator (see contact information below) and specify which aspects of the data you have provided should be destroyed. If you do not want to answer some of the questions you do not have to, but you can still participate in the study.

Questions

If you have questions or require more information about the study, please contact the McMaster Health Forum at 1280 Main St. West, Hamilton, Ontario, L8S 4L6 or at 905.525.9140 x 22121, or alternatively at: [insert contact details research ethics board in Colombia or Chile].

velezcm@mcmaster.ca

Colombia phone number: +57 320 2661360,

Canada +1 2898871039

Canada: 1966 Main St West.

wilsom2@mcmaster.ca

Canada +1 905-525-9140 ext. 22121

Canada: 1280 Main Street West, CRL-209.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB), and [research ethics board in Colombia/Chile] and received ethics clearance. If you have any questions regarding your rights as a research participant you may contact the Office of the Chair of HiREB at 905 521- 2100 ext. 42013 or the McMaster Research Ethics Secretariat at 905 525-9140 ext. 23142.

CONSENT STATEMENT

Understanding the role of values in the health policy decision-making process about health-system financing: Case studies of Colombia and Chile

Participant:

I have read the preceding information thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this initiative. I understand that I will receive a signed copy of this form.

____

Name	Signature	Date

Person obtaining consent:

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this initiative.

____

Name, role in the research	Signature	Date

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB), and [research ethics board in Colombia/Chile]. The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair of HiREB at 905 521- 2100 x42013 or the McMaster Research Ethics Secretariat at 905 525-9140 ext. 23142.

Appendix 6. Ethical Approval Hamilton Integrated Research Ethical Board -HiREB

29 December 2016

Project Number: 2388

Project Title: Understanding the role of values in the health policy decision-making process about health-system financing: Case studies of Colombia and Chile

Principal Investigator: Dr. Michael Wilson

This will acknowledge receipt of your letter datedNovember 02-2016 which enclosed revised copies of the Application/Protocol and Information Consent Form along with a response to the additional queries of the Board for the above-named study. These issues were raised by the Hamilton Integrated Research Ethics Board at their meeting held on October 18-2016. Based on this additional information, we wish to advise your study had been given ***final*** approval from the full HiREB.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Velez_thesis_case-study_Cover_Letter_spanish_2016-12-21	21/Dec/2016	2
Velez_thesis_case-study_email_spanish_2016-12-21	21/Dec/2016	2
velez_thesis_case-study_interview-guide_2016-12-21	21/Dec/2016	3
velez_thesis_case-study_protocol_2016-12-21	21/Dec/2016	3
velez_thesis_case-study_reb_cover-letter_2016-12-21	21/Dec/2016	2
velez_thesis_case-study_reb_email_2016-12-21	21/Dec/2016	2
velez_thesis_case-study_reb_information&consent-form_2016-12-21	21/Dec/2016	3

The following documents have been acknowledged:

Document Name	Document Date	Document Version
tcps2_core_certificate	20/Sep/2016	One

Please Note: All consent forms and recruitment materials used in this study must be copies of the above referenced documents.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the HiREB meeting on October 18-2016. Continuation beyond that date will require further review and renewal of HiREB approval. Any changes or revisions to the original submission must be submitted on a HiREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

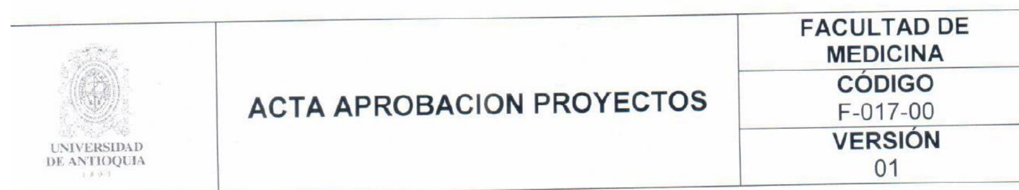
PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

Dr. Raelene Rathbone, MB BS, MD, PhD/Dr. Mark Inman, MD, PhD
Chair, Hamilton Integrated Research Ethics Board

The Hamilton Integrated Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations;for studies conducted at St. Joseph's Hospital, HIREB complies with the health ethics guide of the Catholic Alliance of Canada

Appendix 7. Ethical Approval by the Ethical Committee of the School of Medicine - University of Antioquia (Colombia)



UNIVERSIDAD DE ANTIOQUIA	ACTA APROBACION PROYECTOS	FACULTAD DE MEDICINA
		CÓDIGO F-017-00
		VERSIÓN 01

Acta de aprobación **No. 001**

Nombre del proyecto: **"Comprensión de valores en el proceso de toma de decisiones políticas de financiamiento del sistema de salud. Estudio de caso en Chile y Colombia 2017".**

Investigadora Principal: Claudia Marcela Vélez

Versión No 1

Enmienda revisada: No

Fecha de aprobación: **26 de enero de 2017**

El Comité de Ética del Instituto de Investigaciones Médicas se constituyó mediante Resolución del Consejo de Facultad en reunión del 30 de mayo 2008, acta 177 y está regido por los principios éticos vigentes en la Resolución 003480 del 4 de octubre de 1993, la Declaración de Helsinki de 2008, la Asamblea Médica Mundial y el Departamento de Salud y Servicios Humanos del Instituto Nacional de Salud de los Estados Unidos de Norteamérica Resolución 2378 del 2008. En ellos se delinean las normas científicas, técnicas y administrativas para la investigación en seres humanos.

El Instituto de Investigaciones Médicas certifica que:

1. Se revisaron los siguientes documentos en el presente proyecto:
   a. Resumen del proyecto (NO)
   b. Protocolo de investigación (SI)
   c. Formato de recolección de datos (SI)
   d. Formato de consentimiento informado (SI)
   e. Manual del investigador (NO)
   f. Evaluaciones de otros comités de ética (NO)
2. El proyecto fue aprobado por los siguientes miembros: Dr. Gabriel Jaime Montoya Montoya, Dr. José Antonio García Pereañez, Dr. Julio Cesar Bueno Sánchez, Representante de la Comunidad Claudia Isabel Calderón, Dra. Sonia del Pilar Agudelo López y Daniel Felipe Patiño Lugo.
3. El comité considera que el proyecto no contiene tensiones éticas que vulnere los derechos y el bienestar de los participantes. El riesgo involucrado en el estudio es:
   a) Sin riesgo (X)
   b) Riesgo mínimo ( )
   c) Riesgo mayor que el mínimo ( )
4. El comité considera que tanto la forma de obtención del consentimiento cuando aplica como las medidas tomadas para proteger el bienestar y los derechos de los participantes son adecuadas. No aplica
5. El comité se reserva el derecho de hacer nuevas revisiones del proyecto a solicitud de alguno o algunos de sus miembros o de las directivas institucionales con el fin de revisar lo relacionado con el bienestar y los derechos de los participantes en la investigación.
6. El comité deberá informar a las directivas institucionales correspondientes cualquier evento tocante con faltas de cumplimiento de las obligaciones del investigador en el desarrollo del proyecto, de las solicitudes del comité o suspensiones del proyecto por razones de tipo ético.
7. Se informara a la dirección del Instituto de Investigaciones sobre situaciones como: 1) efectos dañinos que se ocasionen a los participantes de esta investigación; 2) situaciones que signifiquen riesgos para los participantes o

UNIVERSIDAD DE ANTIOQUIA	ACTA APROBACION PROYECTOS	FACULTAD DE MEDICINA
		CÓDIGO F-017-00
		VERSIÓN 01

para personas independientes; 3) cambios ocurridos en el proyecto que fueran aprobados por el comité; y 4) situaciones distintas que de alguna manera puedan influenciar negativamente el buen desarrollo de la investigación.

8. La aprobación de este proyecto tendrá una duración de un año a partir de la fecha de aprobación; si se debe continuar por más tiempo, deberá someterse a aprobaciones anuales hasta la finalización del mismo. El investigador deberá anexar la documentación pertinente para cada nueva revisión del proyecto por parte del comité.

El investigador deberá informar al comité y al Instituto sobre los siguientes eventos:

a. Cambios que se realicen en el proyecto, los cuales deberán ser aprobados en una nueva sesión del comité.
b. Situaciones imprevistas que puedan implicar riesgos para los participantes.
c. Efectos adversos que ocurran en los participantes, en las 24 horas siguientes a su ocurrencia.
d. Alteraciones del rumbo de la investigación que alteren la adecuada proporción entre riesgos y beneficios.
e. Las decisiones tomadas por comités de ética de otras instituciones que participen en el proyecto.
f. Los informes parciales, finales o de suspensión temporal o permanente del proyecto, con las debidas razones que los justifiquen.

El investigador deberá presentar informes parciales del estudio cada (6) meses.

En este proyecto no se encontraron conflictos de interés por parte de los investigadores.

Sugerencias y comentarios: **Debe enviar informe parcial 26 de julio del 2017.**

Nota: Para efectos de la investigación sólo podrá utilizarse el Consentimiento Informado avalado, con el sello del Comité de Bioética.

GABRIEL JAIME MONTOYA MONTOYA
Presidente
Comité de Bioética

Appendix 8. Ethical approval by Ethical Committee Universidad Adolfo Ibañez (Chile)

CERTIFICADO DE ÉTICA

Con fecha 11 de abril de 2017, el Comité Ético de Investigación de la Universidad Adolfo Ibáñez certifica que el proyecto *"Understanding the role of values in the health policy decision-making process about health-system financing: Case studies of Colombia and Chile"*, consistente en la tesis de doctorado de la Sra. Claudia Marcela Velez a presentar ante la McMaster University, Canadá, y en la que participa como coinvestigador en Chile el Dr. Guillermo Paraje, profesor investigador de la Escuela de Negocios de nuestra universidad, cumple con los requerimientos y condiciones establecidas por este Comité.

Para esta decisión se han tenido a la vista un documento con la descripción del proyecto preparado por la Sra. Velez, el diseño metodológico de la investigación propuesta y también el Consentimiento Informado que se presentará a las personas participantes en la investigación. Sobre la base de estos antecedentes, el Comité Ético considera que la investigación propuesta por la Sra. Velez es plenamente respetuosa de la Declaración Universal de Derechos Humanos, del Pacto Internacional de Derechos Civiles y Políticos y del Pacto Internacional de Derechos Económicos Sociales y Culturales de Naciones Unidas, así como de las leyes chilenas y de las regulaciones éticas e institucionales de la Universidad Adolfo Ibáñez.

Tal como ha sido propuesta, la investigación no vulnera la dignidad de los sujetos de investigación y no constituye una amenaza para ellos. La estructura y el fundamento de investigación y la metodología empleada para ello son consistentes con la ética disciplinaria de la investigación. Tal como se indica en el Consentimiento Informado presentado, se efectuarán entrevistas a los participantes en el proyecto y se resguardará estrictamente tanto su anonimato como la privacidad y confidencialidad

de la información recolectada. Se establece también que la participación de los encuestados en el estudio es voluntaria y que ellos pueden dejar de tomar parte en él cuando lo estimen conveniente. Asimismo, si lo desean, los participantes podrán contactarse con el Investigador Responsable para obtener información acerca de los resultados del proyecto.

Por su parte, la Investigadora Responsable se ha comprometido a informar a este Comité respecto de cualquier dilema ético que pueda surgir en el transcurso de la investigación y a resolverlo con prontitud.

En consecuencia, el Comité Ético de Investigación de la Universidad Adolfo Ibáñez autoriza a la Sra. Claudia Marcela Velez, Investigadora Responsable, y al Dr. Guillermo Paraje, coinvestigador, para llevar a cabo su investigación, dado que se ajusta a las condiciones establecidas por esta institución y está de acuerdo con normas internacionalmente aceptadas.

Paula A. Rojas S.
Presidenta

L. Fernando Erbetta D.
Secretario Ejecutivo

Comité Ético de Investigación
Universidad Adolfo Ibáñez

Appendix 9. Interview Guide

Understanding the role of values in the health policy decision-making process about health systems financing

Questions for Stakeholders Interviews

Introduction

- Introduce self (name, and position).
- Confirm that the respondent has an hour available to do the interview.

First of all I'd like to thank you for your interest in this research study and for taking the time to be interviewed. As you may recall from the invitation letter I sent you, the purpose of this research is to understand how and why values are used in the policy-decision making process regarding health-system financing.

Your role in the study involves sharing your perspective on how and why values inform the policy decision-making about health-system financing in Colombia/Chile.

Do you have any objections to the interview being recorded? The recordings will be kept confidential and no direct attribution will occur in any of the study reports.

To start, I would like to clarify what is meant by values in this research. The role of values in health systems is frequently related to doctrines in health professions (e.g. medical ethics), institutional guiding principles (e.g. those included in an institution's mission, vision, and values), or individual preferences and morals (e.g. values and preferences of patients). Every health system in the world embodies values that guide political decisions, and every health-system policy decision is value-laden. The concept of values does not have a precise definition or meaning, but we have selected one that fits with the policy focus of this research: "*values are principles, or criteria, for selecting what are good (or better, or best) among objects, actions, ways of life, and social and political institutions and structures. Values operate at the level of individuals, of institutions, and of entire societies*".

With this definition in mind, values can be organized into five categories, which include basic values, spiritual values, moral values, social and political values, and specific values. In this research, we are focused on social and political values, which refer to sensibilities dealing with general social functioning, such as justice, participation, and equity. In health systems it is possible

to identify a core set of values commonly related to the policy decision-making, with some common examples including: “health care as a right”, “solidarity”, “choice”, “autonomy”, “security and protection”, “efficiency and effectiveness”; “maximization or optimization”; and “sustainability”. Besides those common values, Chile/Colombia explicitly stated in the laws that organize and regulate the health systems the following values: equity, justice, health-care access, timely access, quality and financial coverage (for Chile); universality, solidarity, efficiency, equality, obligation, prevail of rights, special protection to children, differential approach, equity, quality and professional suitability, social participation, progressiveness of rights, free choice, sustainability, transparency, administrative decentralization, complementarity and competition, joint responsibility, inalienability, intersectorality, prevention, continuity, integrality, unattachable, availability, acceptability, accessibility, pro homine, timely access, interculturality, protection of indigenous peoples, protection to peoples and indigenous communities, ROM, black, Afro-Colombian, Raizal and Palenques; institutional autonomy, agreement, and unity (for Colombia).

With this in mind do you have any questions before we begin the interview?

Can you please tell me your job title and position?
And how long have you been in this position?

General Discussion of Values in the Health Policy Process

The first part of the interview includes general questions about values and how and why they fit into the health policy process. Although values underpin the goals pursued in health systems, including how health systems benefit the population, it is often not clear how values are incorporated into policy decision-making about health systems.

1. When we talk about health policy decision-making do you think values are an important input to decisions about health systems? About health systems financing more specifically? Why or why not?

2. What values do you think are most prioritized or fundamental to informing policy decision-making about health system financing in Colombia/Chile?
   - Have you considered other values? Why were some prioritized over others?

3. What do you think are the prevailing dominant values that are informing the government’s current agenda about health-system financing?

4. How and why do values play a role in determining which issues government decides to take action on, particularly in the area of health systems financing?
    - Do they have a role in identifying or prioritizing the problems to be considered by the government?
        i. Prompts: selection of indicators, interpretation given to feedback, framing?
    - Do they play a role in why some policy alternatives are considered over others?
        i. Prompts: reliance on diffusion, interpretation given to feedback, use in communication/persuasion
    - Do they have a role in shaping the political factors that determine whether a government prioritizes some issues over others?
        i. Prompts: linked to events within government, linked to change in balance of organized forces.

5. Colombia/Chile doesn't provide full public coverage and has private for-profit delivery of care that is paid for privately (either through insurance or out-of-pocket). Do you think values have played an important role in shaping this structure of health system financing in Colombia/Chile?
    - Why or why not?
    - Which values have been most prominent in these decisions?
    - How do you think values played a role in these decisions?

6. How and why do values play a role in current policy decisions about health system financing?
    - Do they have a role in shaping the structure of health system financing?
        i. Prompts: resource and incentive effects, interpretive effects?
        ii. Prompts: policy development, implementation of a particular policy?
    - Do they have a role in what interest groups (e.g. physicians, insurance companies, pharmaceutical companies, patients associations, lawyers) are pursuing or how they influence decisions about health system financing?
        i. Prompts: policy development, implementation of a particular policy?
    - Do the public values influence policy decision-making about health system financing?
        i. Prompts: policy development, implementation of a particular policy?

Specific Discussion of Values in the Health Policy Process

That's all of the general questions about values in the health policy process. Now I would like to turn to some questions about values in specific policy decisions about health system financing in Colombia/Chile.

Colombia

- The decision of the Constitutional Court to declare health as a fundamental right implies a change in the notion of health as a public service.
- The Health Ministry of Colombia has developed a mechanism to define the technologies and services excluded of be funded with public budget.

Chile

- The government of Chile passed the AUGE-GES plan. (This plan is universal and constitutes the floor coverage for all users).
- The government of Chile has passed the Ricarte Soto Law to fund high cost diseases.

7. What values do you think were involved in this decision?

8. How and why did values play a role in taking this issue to the government decision agenda?
    - Did they have a role in identifying or prioritizing the problem to be considered by the government?
        i. Prompts: selection of indicators, interpretation given to feedback, framing?
    - Did they play a role in why some policy alternatives were considered over others?
        i. Prompts: reliance on diffusion, interpretation given to feedback, use in communication/persuasion
    - Did they have a role in shaping the political factors that determined whether the government prioritizes some issues over others?
        i. Prompts: linked to events within government, linked to change in balance of organized forces.

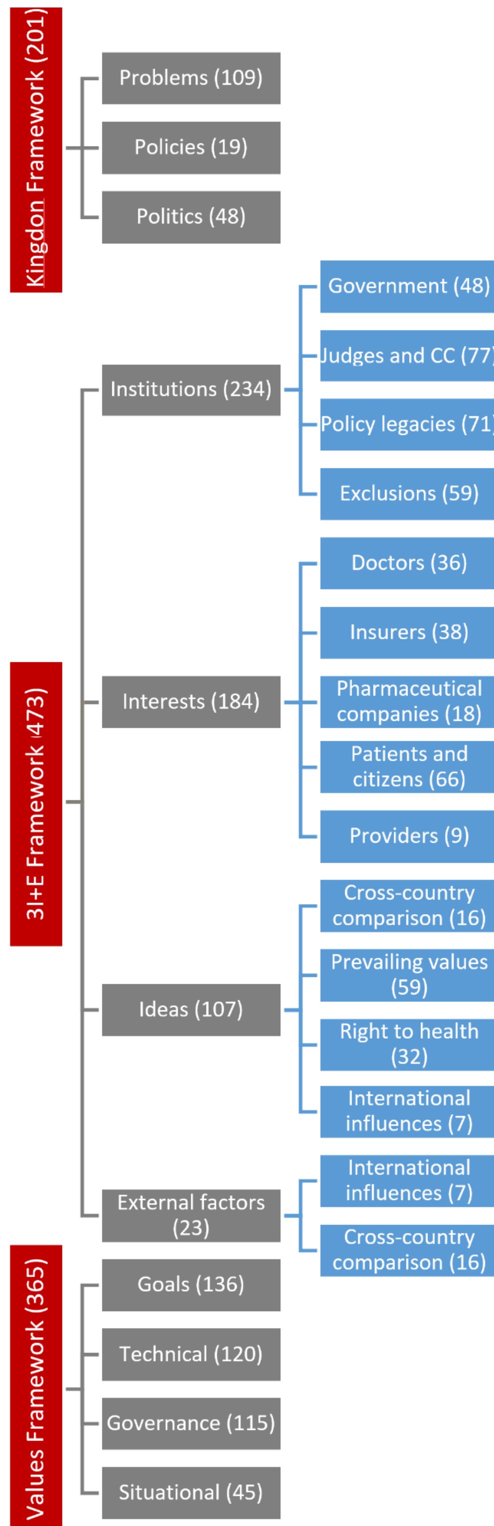
9. How and why did values play a role in this decision about health system financing?
    - Did they have a role in shaping the structure of health system financing?
        i. Prompts: resource and incentive effects, interpretive effects?
        ii. Prompts: policy development, implementation of a particular policy?
    - Did they have a role in what interest groups (e.g. physicians, insurance companies, pharmaceutical companies, patients associations, lawyers) were pursuing or how they influenced decisions about health system financing?
        i. Prompts: policy development, implementation of a particular policy?
    - Did the public values influence this decision? Why or why not?
        i. Prompts: policy development, implementation of a particular policy?

10. Do you think those values were appropriately used? Why or why not?

11. What values do you think were important for informing these decisions, but were not prioritized? Why do you think those values weren't prioritized?

Thank you very much for answering these questions and sharing your perspectives. Do you have anything you would like to add to any of the issues we've discussed?

Appendix 10. Open coding and categories



Chapter 5. Conclusions

The three original research studies presented in chapters 2-4 of this thesis contribute to an increased understanding of the roles of values in policy decision-making about health system financing in Latin American countries. Compared to previous scholarship in this area, my dissertation presents a unique approach by focusing at the health system level as opposed to the professional level, and specifically in Latin American countries. In addition, the application of political science frameworks offers key insights about the ways in which policymakers and stakeholders use values in policy development processes. This chapter begins by summarizing the principal findings from the thesis, as well as strengths and limitations, implications for policy and practice, and areas for future research.

Principal findings

The thesis incorporates a mix of methodological approaches to develop an understanding of the roles of values in the health policy process. Chapter 2 employs a critical interpretive synthesis methodology to develop a theoretical framework, which can be thought of as a heuristic that could be used by policymakers to identify and understand how values have been and are being used in the process of agenda setting, policy development, and implementation in the context of changing historical/political conditions in Latin America. This framework has four categories of values: 1) goal-related values (i.e. guiding principles of the health system); 2) technical values (those incorporated into the instruments and strategies adopted by decision makers to ensure a sustainable and efficient health system); 3) governance values (those applied in the policy process to ensure a transparent and accountable process of decision-making); and 4) situational values (a

broad category of values that represent competing strategies to make decisions in a health system). I further identified four factors that influence how situational values come to be influential in policy decision-making about health system financing in Latin America, which include when they are aligned with: 1) policy legacies (institutions); 2) strong interest groups (interests); 3) values of the government (ideas); and 4) international influences (external factors).

In Chapter 3 the focus narrowed to investigate in greater depth the role of declared values in policy decision-making about health system financing in Latin America through a multiple-case embedded design study with a discourse analysis of media and public documents related to two policy decisions in each of Chile (the AUGE/GES Plan and the Ricarte Soto Law) and Colombia (declaration of health as a fundamental right and the mechanism developed to exclude technologies that could not be publicly funded). The analysis drew on the framework developed form Chapter 2 as well as Kingdon's agenda setting framework and 3I+E framework to analyze the two decisions in each country.

The findings of the discourse analysis highlight that in both countries, the development and implementation of policies protecting the right to health created a discourse - about what should be included or excluded from this protection - which subsequently reached each government's agenda. In Chile, the AUGE/GES plan, which covers a basket of services for a set of prevalent diseases, implied the exclusion of rare diseases and high-cost treatments. This policy decision subsequently created the conditions for a new equity-related problem. Over time this problem was brought to prominence on the government's agenda by Ricarte Soto, who sparked action and created the opportunity and conditions needed for patients with high-cost diseases to advocate for appropriate healthcare in the Chilean health system. The development of the Ricarte Soto Law, therefore, implied a shift from strictly technical values (which decided the diseases and

technologies covered in the AUGE/GES plan) to values like social participation and equality. Principally, the Ricarte Soto Law implied a different approach to equality, given that in the AUGE/GES plan equality was considered as the same basket of services for all the Chileans independent of income and system of insurance, whereas in the Ricarte Soto Law the approach focused on providing needed healthcare independent of the prevalence of the disease and the cost of the treatment.

In Colombia, the decision to consider health as a fundamental right required a mechanism to explicitly set boundaries for the right to health and to determine the characteristics or values that make a technology or service deserving to be protected by the right to health and covered with public funds. In this case, the second decision studied implied a shift from the goal-related values dimension (the declaration of a fundamental right) to technical and governance values dimensions (e.g., evidence-based, rationality, social participation, stewardship, sustainability). In both decisions, the Court played less of a role as a source of a potential veto for specific legislation, but rather as the most important actor in health policymaking.(1) The Court reviews the laws and analyzes whether they are reflective of the values of the Constitution and of the Constitutional Court itself. However, as similarly highlighted in a recent study by Hawkins & Alvarez, the Court lacks the ability to consider scientific evidence or technical values (e.g., cost-effectiveness of the interventions, sustainability of the health system) and therefore, its decisions put significant financial pressure on the health system, and represent a "suboptimal means" to develop health policies.(1)

In comparing policy decisions across countries, the introduction of the rhetoric about the right to health to guide policymaking in both countries was identified as a key commonality. However, the approaches used and the stakeholders that introduced this rhetoric in the policy

process differed. In Chile, the approach was more pragmatic and was linked to discussions at the level of the executive branch (i.e., the president, the health ministry, and the finance ministry). In Colombia, the approach to the right to health was more philosophical and was embedded in broader discussions about what the health system ought to achieve and was promoted by the judicial branch through the Constitutional Court. This is a unique finding to this study, as it has documented how a non-traditional branch of power may strongly influence the policy decision-making in some countries. Additionally, the findings in Chapter 3 identified that the value of social participation has been introduced very recently in the process of policy development in both countries. Similar to the finding in chapter 2, social participation has been often used as a strategy of the government to reinforce the symbolic identification of health with democracy, and to legitimize policy choices. Only recently, has social participation has been recognized as a value that would improve health system performance and the achievement of improved health outcomes. In this approach, patients are no longer just defenders of their interests but are participants in a deliberative societal prioritization exercise with the goal of achieving common objectives and benefits.(2)

When the four embedded decisions are considered in the political context of each country, the values entrenched through large structural reforms are central to shaping the many incremental changes made to health systems in subsequent years or decades. Therefore, these large structural reforms serve as inflection points in policy development as they determine the values that shape the health system over time. For decisions about the large structural reforms studied, it is the world views and values of policymakers who are strongly committed to the reforms (i.e., policy entrepreneurs) and the prevailing values of citizens and interest groups at the time of the decisions that contribute to spurring such large changes that ultimately lead to the long-term entrenchment of these values.

Chapter 4 continued with a more narrow and more in-depth focus on health system financing through a multiple-case embedded study design with the same policy decisions in Chile and Colombia and the same analytical frameworks. However, data were collected through in-depth qualitative interviews with policymakers and stakeholders that were engaged in the policy development processes for each decision. This allowed for a rich qualitative assessment of how and why policymakers and stakeholders in both countries perceive the roles of declared values (which were not possible to analyze in Chapter 3 from media coverage and policy documents), as well as undeclared values (which were only possible to gain insight about through interviews with those involved in the policy development process).

In this multiple-case embedded study, several values were identified as important to the decisions, with only one undeclared value identified (individualism in relation to AUGE/GES plan in Chile). Among these values, a tension between two important values was identified for each decision (e.g., solidarity vs. individualism for the AUGE/GES plan in Chile; human dignity vs. sustainability for the declaration of the right to health in Colombia). This smaller set of prioritized and often competing values is a stark contrast to the findings of the discourse analysis in Chapter 3, where it was found that many diverse values were articulated in policy documents and the media as being important for the same decisions. This difference is more than a simple divergence in quantity, as it relates to how individuals consider values in decision-making: they simplify the complex interplay of values influencing a particular decision to a few elements (values) that represent the extremes of the spectrum of points of views and policy alternatives to solve a problem. This suggests that this process of dichotomizing values that are in tension in decision-making processes makes it easier for policymakers and stakeholders to identify and prioritize

essential values in the policy process, which explains why a small set of values are indeed incorporated in the decisions.

In general, four mechanisms for how values influence decision-making were identified, which include framing problems in meaningful ways, guiding the policy development process (i.e., the process of identifying potential solutions to identified problems), using them as pragmatic instruments to make decisions, and using them to legitimize decisions. In analysis of the policy decisions in Chile, it was identified that values were also used as a way to ensure social mobility among citizens, and specifically to legitimize decisions that were meant to deflect attention from budget constraints (e.g., some stakeholders perceived that the creation of some baskets of services lacked common sense, but policymakers used the values of rationing to hide budget constraints). In the analysis of policy decisions in Colombia, it was identified that values were also used to gain legitimacy in the policy-making process in the absence of meaningful citizen participation, and to shape policies in a way that is aligned with the ideas of an influential interest group.

Another principal finding of this study is that in Chile, policy legacies (e.g., the choice of being able to join the publicly financed or privately financed health system) and values of citizens (the privately financed health system is considered a benchmark of social mobility) explain why individualism and free choice became important in the AUGE/GES plan. In this scenario, solidarity is the value that has not been addressed in the past policies, which came to create a tension in the decision-making in Chile. In contrast, values in Colombia that were aligned with the ideology of the Constitutional Court became influential in health policy decision-making. Moreover, despite Chile and Colombia sharing similar political and economic contexts, there is significant judicial activism in Colombia, but not in Chile. While study participants did not provide explicit explanations for this difference, the analysis of the decisions in Chile revealed a more

pluralist approach to agenda setting and policy development, while in Colombia policy decision-making was influenced by few factors other than the president. We hypothesize that this circumstance facilitated and legitimized the judicial activism in the two policy decisions given that the Constitutional Court has intervened as a constitutional check on the power of the executive branch/president to spur action towards policy development in areas where existing health policy has been viewed as not living up to constitutional requirements.

Study contributions

Together, the three original research studies presented in chapters 2-4 of this thesis contribute to developing an understanding of the roles of values in the policy decision-making about health system financing through: 1) a theoretical framework describing how and under what conditions values inform the policy decision-making (chapter 2); 2) understanding how declared and undeclared values inform four decisions in Chile and Colombia (chapters 3 and 4); and 3) understanding why some values are incorporated in these four decisions in Chile and Colombia (chapters 3 and 4). As a whole, the dissertation makes substantive, methodological and theoretical contributions, which are discussed below.

Substantive contributions

Substantively, the dissertation provides an in-depth understanding of the roles of values in health-system financing decisions using a mix of synthesized and qualitative evidence. The CIS in chapter 2 incorporates a broad range of systematically and transparently synthesized documents to develop the theoretical framework about the roles of social and political values in government agenda setting and policy development, and implementation for health system-financing decisions.

Chapter 3 presents a discourse analysis of how declared values have informed two health-system financing decisions in each of Chile and Colombia. In chapter 4, the findings from the discourse analysis are enriched through a qualitative analysis of "how" and "why" policymakers and stakeholders in Chile and Colombia perceive the role of declared and undeclared values in the same four decisions.

Methodological

The methodologies selected in this thesis aim to achieve both broad and deep understandings of the role of values in decision-making about health-system financing in Latin American countries by moving from a general and descriptive focus to a specific and explanatory focus. First, a critical interpretive synthesis was used to develop a theoretical framework that identifies how and under what conditions values inform policy decision-making about health system financing in Latin American countries. Moving to a narrower and specific context, an embedded multiple-case study design was used to explore the role of values in decision making related to specific health policies in Chile and Colombia, drawing on established analytical frameworks derived from the political science literature (Kingdon's agenda setting framework, and the 3I+E framework that explains policy development and implementations decisions), but using them in a novel way by combining them with the newly developed values framework from chapter 2.(3)

I combined a multiple-case embedded methodology with a discourse analysis of media and public documents in chapter 3 and with extensive key-informant interviews in chapter 4. A multiple-case embedded methodology was used as the common starting point for each study but then used different data sources and analytical approaches in each chapter (discourse analysis of

media and documents in chapter 3 and key-informant interviews in chapter 4).The combination of both methods strengthens the findings in chapters 3 and 4 as it allows for a common thread through both chapters by focusing on the same countries and decisions. Moreover, it allows for rich comparisons within and between countries in each of the studies, as well as across the two studies to a rich comparison of the role of declared and undeclared values based on what documents articulate as compared to what policymakers and stakeholders shared.

Theoretical

This dissertation provides theoretical contributions to the understanding of the roles of values in the policy decision-making about health-system financing in Latin American countries. The theoretical framework presented in chapter 2 identifies four categories of social and political values (i.e., goals-related values, technical values, governance values, and situational values) playing different roles in government agenda setting, policy development, and policy implementation. The framework also identifies four conditions under which values influence the policy decision-making about health system financing in Latin American countries (i.e., when aligned with policy legacies, with strong interest groups, with values of the government, and with international influences). The theoretical framework can be thought of as a heuristic that could be used by policymakers to identify and understand how values have been and are being used in the process of prioritization, policy development, and implementation, in light of the changing historical/political conditions in Latin America. Additionally, policymakers could use the framework to focus their policies according to their objectives (i.e., to achieve important goals, improve efficiency, gain legitimacy, or respond to external influences). Stakeholders interested in influencing policy agendas could use this framework to identify which values support or compete

with the issues they want to prioritize and the policies they think should be used to address them and/or how to make them more technically sound or socially supported. Moreover, the theoretical framework was operationalized in chapter 3 using data from documents and media, and in chapter 4 using interviews.

Strengths and limitations

As a package, the studies presented in this dissertation have four main strengths. First, compared to other scholarship within the field of health policy, the studies taken together are the first to explore the role of values in the policy decision-making about health system financing in Latin American countries. In Latin America, research on values to date has been limited to exploring the incorporation of specific values in the health system and or in health-system reforms or changes.(4–6) Indeed, in my search for evidence, I did not identify any systematic reviews that focused on values in Latin American health systems.

A second strength of the dissertation is the strong connection between the three studies. The critical interpretive synthesis in chapter 2 was used to develop a theoretical framework that identifies how and under what conditions values inform the policy decision-making about health-system financing in Latin American countries. This theoretical framework, along with Kingdon's agenda setting framework and the 3I+E framework, are combined in a novel way with a multiple-case embedded methodology, using a discourse analysis of media and public documents in chapter 3, and extensive in-depth interviews with policymakers and stakeholders in chapter 4. The combination of the discourse analysis with the in-depth interviews strengthens the findings as it allows for a common thread through both chapters by focusing on the same countries and decisions. Moreover, it allows for rich comparisons within and between countries in each of the

studies, as well as across the two studies to better understand the role of declared and undeclared values and based on what documents articulate as compared to what policymakers and stakeholders shared in the interviews, including their insights about how values were used to inform decisions.

The third strength of the dissertation is the comprehensiveness of the sources of information to understand the role of values in the policy-decision making about health system financing in Latin American countries. Those sources were scholarly literature in chapter 2, policy documents and media in chapter 3, and key informant interviews with policymakers and stakeholders in chapter 4. The variety of sources of information in addition to the range of research methods applied, yielded a deeper understanding of the role of values in the policy decision-making about health-system financing and allowed for the identification of consistencies and inconsistencies across sources, and the inclusion of different points of view.

There are also three possible limitations to the studies presented in this dissertation that should be noted. The first is that terms used in the literature about values were diverse and at times vague. Therefore, the search strategy used in the CIS in Chapter 2 may not have captured all of the terms and concepts related to this topic. However, a rigorous process of inclusion assessment was conducted independently by two reviewers to ensure that different concepts, approaches, and reflections of values were considered.

A second possible limitation is related to the recency of the Ricarte Soto Law in Chile (enacted in 2015), and the mechanism established by the health ministry to explicitly exclude technologies that cannot be funded within the available resources of the publicly financed health system in Colombia (defined in 2016). Given how recent the decisions were at the time of analysis, there was limited information from media and policy documents that would allow for contrasting

different points of view or developing an in-depth understanding of the implications of their implementation. However, while identifying this information was not possible through a discourse analysis of publicly available documents, the findings from this study are complemented by those of chapter 4, which used interviews to fill this gap.

The third possible limitation of the dissertation is related to the number of participants and composition of the sample of participants in the embedded multiple-case study in chapter 4. In Colombia, the number of participants interviewed was more than double the number interviewed in Chile, which was partially driven by more participants having been invited in Colombia in order to engage a broader array of people with different ideological positions and professional backgrounds given the significant polarization of the perceptions about the health system in Colombia. In Chile, the agreement between different views of the health system and the values that inform the decisions were greater and, as a result, we reached saturation with fewer participants. The other difference that accounts for the imbalance in participants from each country is that in Colombia policymakers belonging to the judiciary, legislative, and executive branches were interviewed, while in Chile only policymakers from the executive were interviewed. The principal reasons for this are that the judiciary branch is not involved in the health policy decision-making in Chile and that during the fieldwork for this study Chile was in an electoral period and, as a result, it was not possible to conduct an interview with a member of congress during that period of time. This limitation was minimized through data collection in the discourse analysis (chapter 3), where all of the media coverage about these decisions, as well as the transcriptions of public debates about AUGE/GES plan in the Chilean congress were analyzed. This analysis did not reveal a divergence between the statements of members of congress in those hearings and the insights of policymakers participating in this case study.

Implications for policy and practice

The thesis presents three main implications for policy and practice. First, the results of the critical interpretive synthesis and the framework that emerged from the synthesis are useful for policymakers and stakeholders in any country. Both groups can use this framework to identify and understand how values have been and are being used in the process of prioritization, policy development, and implementation in light of the changing historical/political conditions in Latin America. Policymakers could use the framework to focus their policies according to their objectives (i.e., to achieve important goals, improve efficiency, gain legitimacy, or respond to external influences), while stakeholders interested in influencing policy agendas could use the framework to identify which values support or compete with the issues they want prioritized and the policies they think should be used to address them and/or how to make them more technically sound or socially supported.

Second, the findings of chapters 3 and 4 are important primarily for stakeholders and policymakers. For stakeholders, the values that emerged related to the decisions can inform how particular proposals or initiatives should align with the national mood to influence the decision-making. For policymakers, the findings present different points of view about how technical, social, and political values are important in designing policies that meet the needs of the population and responding to citizens' preferences.

Third, this study could potentially help policymakers and stakeholders in other Latin American countries or other low-and-middle income countries in the world. For example, countries confronted with discussions about the incorporation of values in policy decision-making processes, or in the development of policies to guarantee the right to health, might find the

experiences of Chile and Colombia as a useful source of policy learning by comparing and contrasting these experiences to their own situation.

Future research

While the dissertation contributes to the understanding of the roles of values in the policy decision-making about health system financing in Latin American countries, two primary areas for future research emerged. First, there is a need to explicitly test the theoretical framework as a tool beyond the unique circumstances of Latin America (e.g., the post-dictatorship transition to democracy and, in the case of Colombia, the judicialization of health, and with the case of Chile, the association of purchasing private insurance with social mobility). Testing could involve a multiple-case study design for "theoretical replication" of the tool.(3) For example, cases could consist of at least four different health systems, with diversity in terms of country classification (high-income countries and low- and middle-income countries) and geographical distribution. Similar to the methodological approach used in chapters 3 and 4, data sources would include media, documents and key informant interviews. The multiple-case study design would allow for testing of the tool to investigate if it accurately identifies and explains how and under what conditions values play a role in the policy process.

A practical application of the framework could be use it to develop a tool that can support policymakers to consider and use values for informing the policy decision-making. This could focus on guiding them in how to consider each of the categories of values for a particular decision. For example, this pragmatic tool could help policymakers in the development and implementation of policy proposals aimed at achieving universal health coverage. The tool could guide the identification of other goal-related values that might be addressed by the proposal (e.g., equity),

help to assess if a policy proposal is technically feasible (e.g., is efficient and sustainable), analyze which governance values are necessary to improve the acceptability and legitimacy of the proposal (e.g., social participation, stewardship, transparency), and identify situational values that might affect the feasibility or acceptability of the policy proposal in a particular country (e.g., in this study it was identified that individualism is an important value for Chileans, which implies that any initiative to reach universality should consider this citizen's value).

A second area for future research could focus on strengthening the study of the role of values in policy by conducting case studies in different jurisdictions, considering not only financing decisions but also delivery and governance decisions, as well as considering other policy domains such as policy decisions about social systems, such as education, social security, or child policy. Moreover, this dissertation can serve as the basis for following how values are being used to implement the decisions analyzed in the studies conducted for thesis, or to determine if governments have changed the path of action by prioritizing different sets of values according to specific situational factors.

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