World Development 139 (2021) 105300

Contents lists available at ScienceDirect

World Development

journal homepage: www.elsevier.com/locate/worlddev

Looking out, working in: How policymakers and experts conceptualize health system models in Argentina, Costa Rica, and Peru

Shiri Noy

Department of Anthropology and Sociology, Denison University, Knapp 103-D, 100 West College Street, Granville, OH 43023, United States

ARTICLE INFO

Article history:
Accepted 11 November 2020
Available online 29 November 2020

Keywords:
Health policy
Policy models
Latin America
Health sector reform
Development

ABSTRACT

While research has pointed to the role of foreign models in national policy-making we know less about how and why these models are embraced by experts. In this article I examine how experts in Argentina, Costa Rica, and Peru think about foreign models in health: do they compare their countries' health system to their neighbors' and other regional countries? Or do they expand beyond their surroundings, looking to those countries with more advanced welfare states and health systems, notably European countries? I focus on which characteristics are salient to experts and policymakers in considering foreign models and how we can account for differences. Drawing from a unique dataset of interviews with national policymakers, civil society actors, consultants, and international organization personnel working in health in Argentina, Costa Rica, and Peru I find that broad political and social concerns, rather than strictly health performance, affect how and whether respondents name foreign models for emulation. In Costa Rica, a country with a strong, universal healthcare system, experts are less willing to rely on foreign models, though they do cite desirable traits abroad. In Argentina, the political structure—its status as a federal state, guides many of experts' comparisons. In Peru, on the other hand, experts are much more willing to articulate foreign, especially regional, models. I conclude by discussing the importance of considering policymakers' conceptual frames for understanding policy models and reform in key sectors implicated in development, such as health, especially in the global South.

© 2020 Elsevier Ltd. All rights reserved.

1. Introduction

Understandings of national social and economic development have long been dominated by discussions of ideal-typical models and trajectories, often modelled after Western countries (cf. Rostow, 1990). The growing preoccupation with policy diffusion, whether via lateral borrowing or top-down recommendations by international organizations, has reinvigorated scholarly interest in how foreign models are conceptualized and implemented at the national level (cf, Baldwin, Carley, & Nicholson-Crotty, 2019; Dobbin, Simmons, & Garrett, 2007; Gautier, Tosun, De Allegri, & Ridde, 2018; Noy, 2017). Scholars argue that we must seriously consider the epistemic communities, reference groups, and universes of the possible in which policymakers and reformers operate as these may guide their thinking about desirable (and undesirable) reforms (Franzoni & Voorend, 2011). Other researchers have highlighted the diffusion of foreign models across countries, and how these models, though rarely exported and imported wholesale, are apparent in policy reforms (Béland, 2009; Noy & McManus, 2015). Scholars have identified varied mechanisms for policy diffusion: regional dynamics, the pressures of globalization, cross-national epistemic communities, powerful international financial institutions and international organizations, and emulation of known success stories (Baldwin et al., 2019; Béland & Orenstein, 2013; Kaasch, 2015; Shiffman, 2014). Still, how national policymakers and experts conceptualize foreign models and why certain models are viewed as useful and relevant for national policymaking is little examined. This is to the detriment of our understanding of how and why certain models resonate with policymakers across countries and what characteristics make foreign models salient and desirable across national contexts.

To address this gap, this study draws on data from interviews with national policymakers, civil society actors, consultants and experts, and international organization personnel working in health in Argentina, Costa Rica, and Peru which ask them what model their national health system should seek to follow. There are several possibilities for experts' reference groups and models, and this article examines why and how policymakers justify their preferred health models. In particular, I examine which features of health systems policymakers and other key informants view as salient when conceptualizing possible improvements to their

E-mail address: snoy@denison.edu

https://doi.org/10.1016/j.worlddev.2020.105300
0305-750X/© 2020 Elsevier Ltd. All rights reserved.

own national health systems. My research also uncovers whether policymakers think about positive or negative models—and therefore, if they are more concerned with practices and policies to be avoided, or whether their conceptualization is aspirational. Finally, my research analyzes how policymakers integrate the particularistic features of their national conditions, histories, and trajectories of their health system into their thinking about possible models.

2. Unpacking the mechanics of diffusion: coercive isomorphism, learning, and epistemic communities

The scholarship on policy models and diffusion often uses the presence of similar models, and temporal sequence of policy reform and adoption, to explore mechanisms of international diffusion (Brooks, 2005; Ebbinghaus & Gronwald, 2011; Leimgruber, 2012; True & Mintrom, 2002). This work provides valuable information about diffusion outcomes and the policy reform process but often pays less attention to how policymakers conceptualize these models (as exceptions cf. Jacobs, 2009; Weyland, 2005a). Understanding the ideational transmission and understanding of foreign models and ideas can help indicate how purposeful diffusion is and what drives this emulation.

Scholarship on policy reform and diffusion in developing countries has focused on the ways in which the powerful interests of Western countries and international financial institutions (IFIs) have been brought to bear on national policies in the global South. In this conception, coercive isomorphism in national policies may result from such top-down pressure (Dobbin et al., 2007). This research is of especial interest to development scholars because developing countries are often more susceptible to such pressure given power asymmetries, their disadvantaged position in the world system, lower economic clout, and heightened vulnerability in times of economic and other crises. Findings of this research have been mixed, with scholars finding that in many cases, far from being passive recipients of foreign recommendations national policymakers in developing countries instead may use IFIs as a cover to institute unpopular policies without weathering most of the blame, while others point to the contingent and flexible nature of the implementation of these policy recommendations (Béland & Orenstein, 2013; Kaasch, 2015; Noy, 2017; Steinhilper, 2015; Vreeland, 2003; Weyland, 2005b, 2009).

Some research then takes a more constructivist approach, focusing not only on outcomes as evidence of diffusion, but on the ways in which policies are translated and transformed when traversing national boundaries. A dominant approach has been "evidence-based" and focused on outcomes, even while recognizing the complexity of policy change (Hanefeld & Walt, 2015). The focus has been on how actors learn both from past policies and from foreign models and focuses not only on the timing and extent of diffusion as well as the structural processes which inhibit or promote diffusion but also on the actors central to the diffusion process (Béland, 2016; Jacobs, 2009; Kwon & Kim, 2015). In this conceptualization, globalization is changing not only the incentives and conditions for policy change, but also where and how policymakers seek out information about their own national policies and how these stack up relative to other countries'. Finally, subaltern and critical scholars point to the ways in which foreign models and knowledge are negotiated and reconstructed locally and note that countries in the global South often look both inwards and to their neighbors, rather than to Western countries, for solutions and improvements to local systems and policies (de Sousa Santos & Rodríguez-Garavito, 2005; Draude, 2017).

Models therefore, are typically not imported wholesale. This may be especially true in fields like health where stakes, expertise, and knowledge are may be more closely tied to national values and reputations (Carpenter, 2012). Health implicates questions of identity, rights, and mortality, making it a particularly complex policymaking domain beyond more strictly financial or economic arenas such as pensions. Knowledge does not necessarily need to be consolidated before it travels elsewhere (Jasanoff, 2005) and policymakers may pick and choose those aspects of other systems that they believe are (a) successful and (b) applicable to their own situation. Further, epistemic communities—networks of experts—may help propose polices, and help states identify their interests, thereby influencing not only policy change but ideal models for emulation (Haas, 1992).

In this article, I examine the ways in which policymakers, international organization personnel, and civil society members conceptualize ideal models and make meaning out of other countries' health systems in relation to the national systems in Argentina, Costa Rica, and Peru. In this article I *first*, examine how policymakers' understand and make sense of their health system's current drawbacks and the potential for reform. *Second*, I detail the cross-national variation in how these experts approach the issue of foreign models for healthcare reform. That is, (how) does the national context pattern policymakers' meaning-making, future-imagining, and modelling in healthcare policy reform? *Third*, I investigate what accounts for the features that policymakers identify as salient in selecting models or characteristics that their health system should seek to emulate.

This work contributes to several existing areas of inquiry: *first*, this research contributes to the broader literature on development. Social services including health are increasingly seen as a key component of development and states' contracts with their citizens. However, the ways in which health is understood, provided, and regulated varies broadly, especially in the global South. How policymakers think about health as part of the broader welfare state and the state's contract with its citizens furthers our understanding of how they conceptualize state-society relationships in the context of economic and social development. *Second*, this work is in dialogue with the literature on health policy and health systems in comparative perspective. This literature has emphasized the consequences of different health systems for mortality and morbidity, health disparities, and the relationship between financing structures and access and health outcomes and inequalities. However, it is less clear if these are the features that policymakers consider the most salient in crafting and imagining possible health system futures. *Third*, this research contributes to the literature on policy making and meaning-making more broadly—that is, before policies are enacted and attempted, how do key actors conceptualize successful policies and models at the national level?

3. Why Compare? Ideas, Imaginaries, and Model-Borrowing

In her comparative book examining the interface between science and politics Jasanoff notes that: "any expectation that other policy systems can be used as models to imitate rests on a notion of cultural deficit" (2005, p. 291). This statement forces us to engage with questions of power and hierarchy in understanding of development, suggesting that models are guided by understandings of lacking in local systems. However, policy-makers across countries do use models, most assiduously, in determining the possible courses of action and situating their realities. While political culture and policies are embedded in a matrix of experience and practice these include experiences and practices of "others"—in this case other countries. Our understanding of the ways in which models are conceptualized, imported, and reconfigured must account for the cultural dimensions of ideas of progress and development, and ideal health systems. Understanding these concepts may provide insights about which features and practices are most

salient for actors involved in health sector reform, and how they discuss but also justify their ideal policy reform trajectories.

Sociological institutionalism is an approach which is sensitive to institutional and governance dynamics and explores the ways in which "discourses and concepts become embedded in practices" (González & Healey, 2005, p. 2057). Particularly relevant to examinations of models in relation to policymaking, sociological institutionalism expects that in conditions of uncertainty social macrostructures and institutions will feed into scripts (Beckert, 2013). Sociological institutionalism's focus on ideas and cultural templates can be juxtaposed with behavioral economics which expects that when faced with complexity and uncertainty, heuristics will guide decision-making. Both these approaches stand in contrast to the rational expectations approach which suggests that decision-makers make calculations based on rational expectations (Beckert, 2013). Presuming that policy-makers are strictly rational, however, may be a mistake. Weyland finds that in conceptualizing both health and pension policy reform in Latin America policymakers can be viewed as employing a "bounded rationality." That is, rather than engaging in systematic international and historical comparisons policymakers "are attracted to certain foreign experiences for more "accidental," logically arbitrary reasons, including geographic and temporary proximity" (2009, p. 6).

Policymakers then are likely to rely on shortcuts, and are especially drawn to bold, coherent, and simpler reform models (Weyland, 2009). Empirically, Weyland (2009) notes that this strategy was more apparent in pension than in health reform, possibly because in health there are complicating questions about patient satisfaction and outcomes, medical training, facilities, social barriers, and a host of other considerations. In contrast to "imaginaries" and "fictionalities," models are more tightly packaged, and are likely to be more grounded than general expectations or narratives and scripts that guide people's ideas in emulations.

4. Modelling Healthcare: when and why experts look outward

Modelling then raises questions about ideas and ideal types, but also the stories that policymakers construct in order to make sense of their complex experience (Jasanoff, 2005). While models are by definition simplifications in both the scientific sense but also in the policy realm, bound to encounter complex and messy realities, they are helpful tools by which to conceptualize and map goals. Blyth (2002) argues that in times of crisis, ideas reduce uncertainty (39) and salient ideas in discussions of health systems include questions about public versus private provision, universal healthcare, and considerations of equity and health outcomes and disparities (Immergut, 1992; Labonté & Schrecker, 2007; Morgan, Ensor, & Waters, 2016).

Models can therefore be seen as aspirational ideas, or templates that point out what should or should not be done. Models assist policymakers in determining what makes "good policy" and act in ways to legitimate and motivate certain kinds of reform and action. On the negative side, models to avoid are part of policymakers' and experts' "boundary work" (Gieryn, 1983) – where one country's policies are distinguished from another's that is framed in a negative light, typically to point out their own particularity or superiority. Policy analysis can then bridge from the empirical and analytic to the prescriptive, and cross-national models provide such (positive or negative) prescriptions.

The study of the politics of health is a particularly interesting arena to examine policy models for three primary reasons: *first*, the prevalence of ideas of rights to health access, *second*, the importance of health in identity, and *third*, the important role of technology and expertise in healthcare (Carpenter, 2012). In particular, Carpenter notes that the organization of healthcare is uniquely reliant on "the co-organization of expertise and state power" (2012, p. 298) in ways that other domains are not.

Existing research and insights suggest several propositions or expectations about possible differences in health models cited by experts. Given information on the importance of models and ideas during times of uncertainty, we might by extension expect that in places where the healthcare system is still, or newly, in flux, and where there is less entrenchment and legacies of leadership with long-lasting continuities, models would be most ubiquitous.

Proposition 1. *Policymakers in countries where the health system is less entrenched and/or in crisis are more likely to invoke foreign models.*

Second, I expect that in places where interests are firmly entrenched and power is concentrated and the health sector is viewed as successful nationally, there may be less willingness to invoke foreign models. When and if foreign models are invoked, I expect them to be those where health systems are similar (cf. Steiner-Khamsi, 2014).

Proposition 2. *In countries with powerful and established domestic actors in the health system, experts will be more likely to highlight the particularity of their own healthcare system, and possibly minimize the utility of foreign model borrowing.*

While the first and second propositions explore whether experts name foreign models, the third proposition suggests which types of models may be invoked. While institutions and frameworks likely shape decision-making this raises the question of which structural conditions will be salient to experts. Given the centrality of debates about the implications for efficiency, equity, and access of public as compared with privately funded and provided healthcare (Morgan et al., 2016) I expect this to be a salient feature in key informants' discussion of desirable and undesirable models. Finally, I expect that where there is a strong public system, especially if it is egalitarian in its provision of services (rather than tiered or segmented based on contributions) and solidary in its financing (for example, subsidized by the state), policymakers will be more critical of privately financed systems.

Proposition 3. *Policymakers in countries where there is a strong(er) public system will be less likely to name (and/or more likely to denounce) mostly private healthcare systems.*

5. Case selection and Background: Healthcare in Argentina, Costa Rica, and Peru

The data in this article are drawn from a broader mixed methods study examining health sector reform in Latin America, focusing on Argentina, Costa Rica, and Peru in recent decades. These country-cases were chosen because they all experienced attempts at health sector reform and represent historical variation in key dimensions of state health autonomy—whether leaders articulated clear goals in health, and state health capacity—whether they were able to carry out these goals or were thwarted—possibly owing to opposition by other powerful actors or lack of financial or other resources (for additional information see, Noy 2017). A small-N design, within a single developing region, allows for careful attention to how axes of difference across countries that may be similar along other dimensions account for variation and allows me to minimize threats to validity by working closely with the three cases and the data, while also providing comparative leverage (Gerring, 2004; Tilly, 1984).

Argentina represents a country with historic high autonomy but low capacity in health where government plans to reform the system in the 1980s were thwarted by the social security sector of the

Obras Sociales, Peru represents a country with low autonomy and low capacity—a weak state in health, and Costa Rica a high autonomy and high capacity country—a strong state in health. As such, these countries represent important variation in health systems, health sector reform, and health outcomes, as elaborated below and summarized in Tables 1 and 2. While I do not argue that these countries are necessarily representative of Latin America or the developing world, I believe that the propositions, data, and arguments presented here, particularly when placed in conversation with existing research on foreign models, policymaking, and diffusion, may be instructive: this analysis provides useful insight to how policymakers and experts across countries conceptualize foreign models, and when, how, and why they find inspiration in other countries' systems.

Table 1 provides an overview of the health systems in Argentina, Costa Rica, and Peru. Focusing on Latin America may be particularly interesting as it has sometimes been described as a "laboratory" for social policy change (Steven & Bujones, 2014), suggesting that policymakers and experts alike are likely to look abroad given often ambitious and frequent changes to social and health systems. Peru is the poorest of the three countries, it is also geographically diverse, and home to a sizeable indigenous population, as such it faces distinct challenges from Costa Rica and Argentina. The health system is segmented: the armed forces and military have their own health system and facilities, the Ministry of Health runs nationwide health posts and hospitals, and charges user fees for services in some cases. The social security system in Peru, EsSalud, serves approximately 20% of the population, and those formally employed are eligible both current and retired, as well as their families. These services are highly concentrated in urban areas. Moving towards universal healthcare coverage, in 2001 the Peruvian government introduced the *Seguro Integral de Salud* (Integral Health Insurance, SIS) which unified two previously existing schemes targeting school aged children and pregnant women. SIS is available to everyone living below the poverty line (Parodi 2005). The SIS program has pursued a strategy of attempting to incorporate groups of Peruvians. They have therefore extended coverage to, for example, women who work in nurseries and kindergartens, leaders of community kitchens ("comedores populares"), etc. (Alcalde-Rabanal, Lazo-González, & Nigenda, 2011). As of 2015 about half of the population was covered by SIS (Gutiérrez, Romaní Romaní, Wong, & Del Carmen Sara, 2018).

Argentina's health system is very different: a highly decentralized country where provincial governments are largely responsible for their own health policies. Broadly, the Argentinean health system is composed of three sectors: public, private, and social security. The public sector is run by the national and provincial governments and its services accessible to anyone requiring healthcare, and it is geared largely towards people not affiliated with the social security system and those unable to afford healthcare. The public sector is financed by public funds and occasionally is reimbursed by the social security system when its subscribers use public facilities. The social security system is obligatory and is organized along broad occupational lines or industrial sectors, and is called *Obras Sociales*. Public employees across the provinces are affiliated with their own *Obra Social* (OS) and there are 24 provincial OS – one in each province. The other *Obras Sociales* are organized along occupational lines, created by professional associations and employee unions. There are over 300 *Obras Sociales*, which have their root in health insurance funds for workers created by trade unions (Belló & Becerril-Montekio, 2011; Belmartino, 2000). There is a separate institute for pensioners the *Programa de Atención Médico Integral* (PAMI) (administered by the National Institute for Social Services for Retirees and Pensioners, *Instituto Nacional de Servicios Sociales para Jubilados y Pensionados*, INSSJP) which is its own OS. PAMI and the *Obras Sociales* together cover about 60% of the Argentinean population (Rubinstein, Zerbino, Cejas, & López, 2018). The private sector consists clinics and facilities that service OS affiliates following from agreements between these affiliates and the OS and private insurance plans (called *Empresas de Medicina Prepaga*, EMP or "prepagas") that can be paid by individuals or companies with resources negotiated with the OS.

Costa Rica is hailed as a health success story of "health without wealth," despite its status as a developing country it has achieved high life expectancy and low levels of infant mortality. It leads Peru and Argentina in both life expectancy and infant mortality despite lower health spending per capita than Argentina as indicated in

Table 2
Health Indicators in Argentina, Costa Rica, and Peru.

	Argentina	Costa Rica	Peru
Life Expectancy (at birth, in years) 2017, source: WB WDI	77	80	75
Infant Mortality (per 1000 live births) 2017, source: WB WDI	9	8	12
Total health expenditure per capita (current US$) 2016, source: WB WDI	$955.20	$888.85	$316.44
Domestic general government health expenditure as a % of current health expenditure 2016, source: WB WDI	74.43%	74.76%	64.07%

Table 1
Comparative Health, Political, and Economic Systems.

	Argentina	Costa Rica	Peru
GDP per capita, (current US $), 2018 source: WB WDI	$11,652.6	$12,026.50	$6,947.30
Structure of the Political and HealthSystem	Federal	Centralized	Centralized
Health Financing	Tax financing for the public system,Obras Sociales (social security): financed by employers and employees	Tripartite: employer, employee, and government subsidies for the poor,	Tax financing for the public system. EsSalud (social security): financed by employers and employees. SIS (state insurance, slowly incorporating different occupational groups): financed users, heavily subsidized by the government. Police and military branch: financed by the government
Health Provision	Obras Sociales (social security) covers ~60% of the population and have their own facilities or subcontract with private facilities. Public hospitals are free.	Universal, the Caja Costaricense de Seguro Social (CCSS) covers over 90% of the population in their own facilities.	EsSalud for formal sector workers (either EsSalud facilities or private facilities, EPS). Ministry of Health facilities provide services for SIS affiliates

Table 2. In 1993 Costa Rica integrated its social security program with the Ministry of Health resulting in a single-payer model managed by the social security program and financed by employers, employees and the government (with subsidies by government for the poor). The main provider of health services is Costa Rica's social security agency, the *Caja Costarricense de Seguro Social* (CCSS) established in 1941, which originally provided health services to formal workers, then expanded to include their families in 1961, and has since expanded to encompass the whole population, and effectively covers over 85% of the Costa Rican population. Therefore, approximately 15% percent of the population, consisting largely of agricultural laborers, informal sector workers, self-employed professionals, and business owners, is without public health insurance. Uninsured people however do use public health facilities despite not being officially insured, especially hospitals (Clark, 2002; Unger, De Paepe, Buitrón, & Soors, 2008).

6. Data & methods

My analysis draws from 88 interviews with key informants, mainly current and former policymakers, in Argentina, Costa Rica, and Peru conducted in 2011. Respondents were recruited via snowball sampling, while seeking broad coverage of important institutions and organizations involved in health sector reform in these countries. Overall I was able to interview over 75% of the unique name referrals from initial respondents, identified via secondary literature and beginning with initial contacts at ministries of health and social security offices.[1] Saturation was reached when additional respondents did not provide new information about health sector reform processes and once I interviewed a representative from all agencies/organizations involved in reforms or named by my respondents. Respondents include both former and current personnel in national social security systems, ministries of health across the three countries, as well as several NGO and civil society staff, experts including consultants and academics active in the health sector, and international organization personnel working in health (mainly from the World Health Organization's, WHO, regional arm: The Pan-American Health Organization, PAHO but also the World Bank). Respondents had the option of remaining entirely anonymous, allowing me to list their full name and institutional affiliation, or only their institutional affiliation, reflected in the citations.

All interviews were recorded and transcribed and mentions of foreign models and reasons for naming these models coded using AtlasTI software. In particular, I first identified what countries and models (and whether one or more than one) were named by respondents for emulation across the three countries and tallied them—a broad category-based analysis (Kuckartz, 2014) and made note of negative models, mentioned as those to avoid. Second, I coded the data in AtlasTI thematically for mentions of health systems, outcomes, and other factors as justifications for models. Third, within those other factors I coded for several dimensions: political systems, cultural factors, and national exceptionalism. I then examined data along these codes to further identify which and what of these themes were invoked in tandem and what and how these justifications were invoked relative to one another, reconnecting the codes, themes, and concepts to one another, within and across countries. I then revisited and organized the data to aggregate and assess patterns within and across countries and draw inferences, particularly in regards to the propositions detailed above (Bazeley, 2013). All quotes presented here are translated by the author as nearly all interviews were conducted in Spanish.

Respondents were asked how their country's health system should proceed in terms of health sector reform, and the analysis below draws primarily from the following interview question: "Now I would like to ask you about the Peruvian/Argentinean/Costa Rican healthcare sector in comparison to healthcare systems in other countries. Different countries have different ideas about the best way to structure social policy and particularly, health services. Do you think that there is any particular country that Peru/Argentina/Costa Rica should imitate/follow in terms of healthcare? Why?" In the interview respondents were also asked questions about their country's health sector, its main strengths and weaknesses, and important stakeholders in health sector reform (reforms were pursued in all three countries, to different extents, in recent decades). This question, therefore, asks respondents specifically about foreign models given the literature on diffusion and to provide a concrete touchstone, priming them to think about the peers and leaders they might aspire to emulate. Follow-up probes asked for additional information or clarification on why these countries were mentioned to interrogate the "why." Data collection via interviews allowed me the flexibility to ask about motivation for naming particular models, and put this information into conversation with respondents descriptions and assessments of their national health system more generally, asked in other parts of the interview.

7. Results

Across all three countries, many respondents viewed health as a sector which in many ways defies borrowing from other contexts. Table 3 provides information about the positive, aspirational models for healthcare identified by participants in Argentina, Costa Rica, and Peru. Table 3 indicates that the modal category across all three countries pointed to the uniqueness of their own health system. This is an especially interesting finding as the question clearly asks about other countries rather than leaving open any and all aspects of health systems to follow, in an attempt to examine modelling specifically given insights of existing scholarship, particularly on diffusion. Across all three countries there was common discussion of improving particular aspects of the current, national system: in Costa Rica there was concern with the viability of financing in the future and the recent financing crisis of the CCSS whereas in Peru there was concern with the fragmentation of the system, limited coverage, and especially access in rural areas and to indigenous people. In Argentina, respondents were nearly as likely to point to Canada as improving aspects of their own system, citing the challenges of a federal structure. Beyond this, I find that respondents identified either regional, Latin American, or developed country, namely Europe and North American, health systems as models for emulation, as shown in Table 3. That is, despite some possible similarities with health systems in other middle income and developing countries, perhaps in Asia, the Middle East, or Africa, these systems are not salient in policymakers' minds when considering health systems to emulate in Argentina, Costa Rica, and Peru. This is consistent with ideas of "bounded rationality" where respondents use regional and other shortcuts and heuristics to think about possible models across countries but also sociological institutionalist understandings where shared social macrostructures pattern modelling (Beckert, 2013; Weyland, 2009).

7.1. Peru

Peruvian policymakers and experts were the most likely across the three cases to cite regional neighbors as exemplars, rather than developed countries. This may be related to the emphasis on the

[1] Detailed information about the sample, and the broader study can be found in Noy 2017.

Table 3
Health Models to Emulate Named by Key Informant Respondents in Argentina, Costa Rica, and Peru.

	Peruvian respondents	Costa Rican respondents	Argentinean respondents
Improve certain aspects/Own country	9	16	10
Latin American Countries			
Brazil	2	1	5
Chile		1	1
Costa Rica	3		4
Colombia	1		1
Cuba	2		
Ecuador	1		
Mexico	1		
Paraguay	1		
Uruguay			3
Developed Countries			
Canada	1	1	9
England	3	3	6
France	2	2	3
Holland		1	
Italy		1	1
Spain		3	2
United States			2

Note: There were 102 models mentioned in 88 interviews as respondents were not restricted to naming a single model or approach given the open-ended nature of the question. This table includes positive models to follow as those to avoid were rarely mentioned, but are discussed in text.

particularities of different regions within Peru and the interest in borrowing more closely in order to increase compatibilities and comparability. It may also speak to more modest, or realistic goals, given its status as a firmly middle-income country, and less developed than Costa Rica and Argentina. Peruvian respondents may then have been less likely to "overreach" in ambition despite the fact that the question did not ask about reachable or manageable ideals, but rather more broadly about emulation of another country/other countries. These responses may then reflect not limited ambition, but rather, limited information about other, non-regional, models and system or other motivations.

Interestingly, given that Peru has the weakest public system and overall health outcomes of the three countries and where we might expect the most consultation with external models given low performance, there was significant hesitation about naming models for emulation. However, for example, one respondent, when asked about models for emulation instead answered with a discussion of the principal problems with the current system stated: "I think that the main problem that the country has is the inequality in access to services. And that there is inequality at every level, not just in the public sector" (Velasquez Valdivia, 2011). This respondent, like several others across countries, therefore suggested improving aspects of the Peruvian system, rather than looking for external models to emulate.

Peruvian respondents were also the most likely to mention negative examples, those that they would not like to see emulated: while one respondent named Chile as a negative example, one named Costa Rica, and two named Colombia (negative models do not form part of the tally in Table 3, since there were only a handful of mentions across the three countries I discuss them in text rather than summarizing them in a table). This indicates that policymakers position themselves by looking outward for models to emulate, but also, though to a lesser extent, those to be avoided. Substantively, the reasons given for models to avoid ranged from the low status of the Ministry of Health in Costa Rica to the marketization of health in Colombia. One Peruvian respondent says of Costa Rica: "The social security in Costa Rica is extreme…social security in Costa Rica is so strong that the Ministry of Health is completely non-existent" (Gonzalvez, 2011). This speaks to the salience of power dynamics and asymmetries within the health system for model selection though this is of-course a matter of perspective. However, three additional respondents saw Costa Rica as a positive model to emulate citing its universalism, and its efficiency in terms of resource use, and excellent health outcomes. Another respondent notes that Costa Rica's health success needs to be contextualized as part of its abolishment of the military, where those public monies were then funneled into health and social security (Salinas Rivas, 2011).

While respondents across all countries mentioned the particularities of their historical and institutional settings which would make copying other models problematic (indeed, the modal approach in all three countries was a preference for their system with the need for various kinds of improvements in areas ranging from quality of services to increased access) respondents in Peru were more likely to mention the issues associated with providing care to indigenous communities and the challenges Peru has in implementing an inter-cultural approach. For example, Ecuador was named as a model for cultural sensitivity in the provision of healthcare: "obviously there has to be a model that has cross-cutting aspects, but that is implemented differently in each [subnational] region, for example, I must understand that health is a right, but the provision of services must be sensitive to different features so it is really this way. In Lima it's as easy as opening a health center and people go. In more remote areas, more scattered in the *selva* [jungle], you open a health post and for what? You have to take into account the cultural aspect and in the *sierra* [mountains] it's the same and in this regard there are very nice initiatives. For example Ecuador, I understand that they have applied in their health services, a very interesting cultural diversity strategy. People come to the [health] establishment and on the one hand you have drug information and nurses, with their health strategies of vaccines, and you also have a [traditional] healer" (Castro Quiroz, 2011).

7.2. Argentina

In Argentina, in contrast, the models named by the respondents were centered on the structure of the health and broader political system: that is, the challenges posed by a federal system. Many respondents drew on the Canadian and English models to propose solutions to issues they identified in the Argentinean system. Nearly as many respondents named Canada as a model as pointed to the uniqueness of the Argentinean health system, though others highlighted access and coverage in countries like France and Spain. As one respondent notes: "the Canadian model, which establishes an agreement between the provinces and the national government in order to define the level of medical attention…Second, the reform in Uruguay is interesting because it has a health system similar to ours" (Tobar, 2011).

Another respondent mentioned different countries for different aspects of the health system, but again, underscores the utility of the Canadian model due to structural similarities: "I think that from an institutional perspective, the Canadian model: establishing national insurance, but at the same time, completely decentralized where the states [provinces] play an important role is a potentially interesting model for Argentina, because the states [provinces] have a lot of autonomy over there [in Canada] to do things" (Vasallo, 2011). Most respondents, even when naming foreign models, qualified the local circumstances which differentiate Argentina from Canada: "I would love it if we had a system like in Canada, for example but well, Canada is Canada, it has its history, Argentina has its history, you can't say "I want that system", it's an ideal, it doesn't exist" (Interview with a consultant and

academic, 2011). In this way, respondents understood that aspirational models would encounter local realities, including historical idiosyncrasies. Another respondent notes that not only does he think that Argentina should look to Canada, but that it has in the past, rather than treating it as an unattainable ideal: "Our reforms always looked to Canada, because it's an English system in a federal country, like ours" (Cetrangolo, 2011).

Some Argentinean respondents, like those in Peru and Costa Rica, had no specific country model, but rather a characteristic, centering on access and by extension, equity: "Universal insurance, recognizing health as a citizen's right translates into providing egalitarian, equitable services and under the protocol of international evidence. I firmly believe in equity as a substantial value in a system of medical care, and I think that with the particularities of Argentina it will have to be single-payer financing" (Glanc, 2011). Another respondent notes that decentralization in health might not be the best option, but that it is financially-driven and forms the political and institutional background against which the health sector operates: "It's interesting to look at why health services were decentralized in Argentina…It was more a fiscal decision than a sectoral [health] decision" (Interview with an Inter-American Development Bank official, 2011). Together, these responses speak to the importance of values and universality, as well as attention to the federal structure cited by most respondents in Argentina.

7.3. Costa Rica

Costa Rica has the strongest health system of the three countries, and arguably in Latin America, both in terms of coverage and health outcomes. It is known globally as a success story of "health without wealth." Not surprisingly, then, the Costa Rican respondents were more likely than their Argentinean and Peruvian counterparts to name their own health system rather than naming a foreign model, though they did suggest some modifications. Namely, the expansion of scope and more coordination across different health entities and sectors beyond health, such as crime and violence, taking a markedly holistic and integrated approach to health, indicative of a distinctive "culture of comparison"[2] there: "It is necessary to consider what health is, at the moment when you speak about health there is a part that is directly attending and treating people, but we speak more of health as of a social result. Then, in the end, it seems to me that then that we need to do further work in the system. Because one speaks, for example, about physical exercise, but unfortunately one does not address the topic of violence or of delinquency: how much exercise can you do it there are no places where you can do physical exercise? So, I believe that the problem is that there is no suitable coordination" (Carazo Salas, 2011). In addition, Costa Rican respondents only named two regional neighbors as exemplars, whereas all other model systems were from developed countries highlighting variation in reference groups that respondents in these countries use in thinking about health models.

While some respondents in Peru and Argentina wanted to nationalize healthcare, in Costa Rica there was a concern with maintaining the public status of the health system and more specifically, worries about increased privatization: "We have to do an analysis, very ours, very national, considering everything what is happening in the world. I am not thinking about following anybody's models anymore, it's become very clear that that is not the correct approach…There are new actors, in the private sector—which has taken a lot of force, more belligerency on its [the private sector's] part to offer hospital services principally, ambulatory services, of advanced technology where lots of money is being spent and that is necessary to take into consideration that this generates an enormous pressure on your [public and social security] institutional finances, because they have to buy, acquire the things" (Salas Chaves, 2011). In this way, these new private actors are framed as threatening the public system, and in particular its viability via competition but also increased demands which has financial implications.

An important difference from the two other countries among Costa Rican respondents was that they explicitly named their own model as the ideal model, despite it requiring modifications, including those detailed above who worried about the challenges of coordination and financing as well as the dangers of privatization. This is in contrast to the Argentinean and Peruvian respondents, who specified changes that needed to be made in their own system without invoking another country or another ideal type model, but did not name their own country as an *ideal* model. For example, one respondent says of Costa Rica's health system: "No, I believe that we should not deviate from the model. The model itself has no problems" (Piza Rocafort, 2011). Another respondent also notes the Costa Rican model, in vision if not in practice: "The Costa Rican [model], universal attention, solidarity based on the style of the Costa Rican social security that has permanent financing, with participation of the beneficiary, the state, and the employers of the insured; but with a vision of integral public health not with the partial vision that the CCSS has of hospital care which is beginning to develop; because many of us have been fighting for this [integral vision]" (Saenz Jimenez, 2011). For some Costa Rican respondents, therefore, the problem is not the model, but implementation that deviates from the model, and the dangers of privatization and a leaner view of healthcare, as compared with the more encompassing, integrated system that had characterized it historically.

Respondents in Costa Rica therefore point to three main attributes that makes the system an ideal model (though its management or execution is sometimes lacking): its universality and uniform access to care, its tripartite funding, and its integral approach to health—where the system conceptualizes health beyond hospitals and other health clinics, also doing work in health promotion and preventative care and considering other social determinants of health. The concern was primarily with maintaining these features in the face of perceived encroachment from reductionist, technocratic, and other pressures. One respondent says: "What I am going to say may sound bold, but I believe that Costa Rica has a very good health system in terms not only of financing that seems to me to differentiate us from many countries, which is the tripartite financing and also that at this moment there is no distinction in that all the Costa Rican people can have access to all services regardless of the complexity of the issue, that makes us different compared to other countries' health systems" (Robles Monge, 2011).

This is not to say that no one mentioned foreign models, three respondents mentioned the Spanish and French systems each. The features cited that make these systems good models were their universal and public nature (Soto, 2011), while another respondent notes that the co-pays in the Spanish system for medications would be useful to emulate given the financial difficulties that the CCSS is having Costa Rica, though this was a minority position (Jimenez Fonseca, 2011).

7.4. Cultures of comparison and salient factors in identifying model countries

Taken together, my analysis suggests that the attributes and legacies of these countries' health systems but also broader political systems affect how and whether they are willing to name foreign models. In Costa Rica, a country with a strong healthcare

[2] I thank an anonymous reviewer for this insight.

system, policymakers are less willing to rely on foreign models, though they do cite desirable reforms and aspects that require improvement: namely issues with the sustainability in the financing of the Costa Rican health sector and concerns about maintaining the inclusionary, universal, and public character of the system in the face of rising costs. In Argentina, the political structure—its status as a federal state—guides many respondents' comparisons. That is, the most salient feature of the system to them, and one that must be considered in order to make valid comparisons, is the federal structure of the state and by extension, health policy. In Peru, on the other hand, policymakers are much more willing to articulate foreign models for emulation, but were most likely to rely on regional and more modest, perhaps realistic, comparators and goals with some, but limited mentions of health outcomes.

Overall, I find support for Proposition 1 and some support for Proposition 2. In Peru, the least extensive (in terms of coverage) and organized (in terms of regulation of private entities, communication between the Ministry of Health and social security, also discussed in other parts of the interviews) healthcare system there is the highest likelihood of invoking foreign models (as indicated in Proposition 1). In Costa Rica, policymakers were most likely to underscore the benefits of the Costa Rican approach to the financing and provision of health, emphasizing the utility of the model, but pointing out some tweaks and issues in implementation and fears for the future. Similarly, Argentinean policymakers pointed to the unique, federal structure of their political system, and to the particularity and power of the *Obras Sociales* in the national healthcare system while those in Costa Rica pointed to the CCSS as the bedrock of its successful model (as indicated in Proposition 2). Respondents in all three countries drew on features beyond health outcomes including broader political-economic features in identifying models and bases for those models. This provides important information that counters a single-minded focus on outcomes in health, and underscores existing understandings of health as a particularly complex and perhaps unique policy context and sector.

My analysis yields mixed support for Proposition 3. While Costa Rican policymakers described the benefits of their solidary, universal system there was also discussion about the utility of introducing competition and sub-contracting in the face of budgetary concerns. The Argentinean case is an interesting in-between case when considering its financing: the *Obras Sociales* are neither fully private nor are they fully public though the public system is available to all. Interestingly, discussions of public and private systems among respondents focused not on outcomes, but rather on undergirding values. Overall, the type of system (private/public) was a salient component but not the most commonly invoked one, and while Costa Rican decision makers were least likely to mention foreign models at all when they did invoke foreign models they highlighted solidarity and universalism.

My analysis indicates that policymakers and experts focus on the structure and strengths of national health systems when looking at models, but arguing that the focus is on health systems alone is incomplete. Further, there is some evidence of different cultures of comparison: related to the centrality of the health system to national identity where a health system that is a point of national pride makes it less open to comparisons (in Costa Rica) but also to broader political institutions which form the basis of many model countries named (in Argentina) and the centrality of cultural variation and distinctiveness within countries as an axis to consider (in Peru). In Peru models were more likely to be Latin American, suggesting an important, more regionally focused culture of comparison. Importantly, the different bases for identifying desirable models are marginalized in existing dominant accounts of diffusion which have focused on outcomes across sectors, including health, and the importance of epistemic communities and top-down powerful international actors in propelling particular models.

The data and results also move beyond the propositions, which were formulated based on existing evidence. In particular, there were few *a priori* theoretical expectations about what features policymakers may highlight in naming models for their health systems beyond the focus on public versus private systems, salient in the health policy literature, and a reliance on neighboring (familiar) countries consistent with "bounded rationality." The empirical evidence allows us to extend our understanding both of when and why key informants name models for their national health system. In particular, I find that negative models were invoked more strongly in Peru, where the health system is actively being reshaped and expanded. The empirical evidence also allows me to examine why policymakers name foreign models: that is, what features are salient in comparison. While discussions of private versus public systems are certainly prevalent, I also find that foreign models are invoked based on political structure (e.g. federalism), and local conditions such as indigenous populations.

8. Conclusion

Studies of development policy suggest that countries' models and strategies are often borrowed and diffused across borders, sometimes pushed by international agencies, in other instances emulated abroad because of proven success. However, there is limited empirical examination of how policymakers and experts think about foreign models. This study examines how respondents conceptualize ideal types for their countries' health system across three Latin American countries. In my analysis, I discuss which features are salient to decision makers and how we can account for differences across these countries.

Several interesting themes emerge of particular importance to the study of model-borrowing and health reform and which advance our understanding of development and social policy. *First*, much of the current policy and academic discussions surrounding health sector reform center around outcomes (that is, ranking systems in terms of morbidity and mortality) and financing (overall spending, as well as public versus private). Interestingly, my analysis reveals that policymakers in Argentina, Costa Rica, and Peru are less likely to point to health indicators (e.g. life expectancy) explicitly, though overall the countries they name as models are those with better population-level health outcomes (and two point to the U.S. as a negative model because of high spending, comparatively poor outcomes in terms of Western nations, and inequality). Most interestingly, it is in Costa Rica, where health outcomes are the best that respondents are most likely to point these out, most often when citing their own system.

That is, though Peru and Argentina perform below Costa Rica on the conventional health measures such as infant mortality and life expectancy (as seen in Table 2) respondents in these countries are also less likely to point to outcomes as a motivation for choosing their model countries. This finding has important theoretical implications for how social scientists can think about model-borrowing and policy change. That is, we often assume that (rational) decision-makers are driven by the perceived payoff of their decisions, but in thinking about national sector-wide reforms, the broader system—it's financing and its structure—appears to be more salient to policymakers than looking at countries with favorable outcomes and working backwards to the organization of the health sector.

Second, there is important variation across the three countries but respondents in each limit their models to regional neighbors and developed countries. That is, consistent with understandings of bounded rationality and heuristics, there are no mentions of

Asian, African, or Middle-Eastern countries despite possible similarities and important lessons to learn from these peers. This suggests a limited "universe of the possible" in terms of policymakers and experts' familiarity with and/or impressions of foreign health systems and models, drawing on more familiar and local, or alternatively, developed health systems in the context of often strong welfare states. This suggests important features of cultures of comparison that vary by countries but may also have shared features in terms of where experts looks to models.

Third, while the health system is distinct than other sectors in several important ways policymakers in Argentina, Costa Rica, and Peru conceptualize its challenges and draw on models for reform from countries that share broader political-economic and structural characteristics and challenges, or in the case of Costa Rica focused on national values. In Argentina then the most often cited attribute for selecting a model was the federal political and financial structure, where Canada was most often identified as a model to follow. In Peru on the other hand, several respondents pointed to countries that were facing similar challenges in extending health services, and pointed to the importance of accounting for geographic differences across regions and Peru's indigenous communities. Finally, when Costa Rican respondents cited foreign models (though they were less likely to do so than Peruvian or Argentinean respondents) they repeatedly referred to the importance of the values underpinning their system: of solidarity and of the public nature of the system. That is, in Costa Rica the CCSS is part of the national identity of the country—it is a core part of what it means to be Costa Rican. This emphasis on the identity underpinning the structure, rather than simply on the structure of the system, financing, etc. is uniquely Costa Rican and was not discussed by respondents in the two other countries. Therefore, I find that variation in the motivations driving what experts perceive as legitimate and informative foreign models vary across the three countries, and highlight the differences both in the health systems themselves, but also the importance of the broader political system (Argentina), geographic and cultural make up (Peru), and national values (Costa Rica).

9. Discussion

This article expands our understanding of how policymakers and experts think about foreign models and ideal types, filling a gap in the literature that has focused on mapping diffusion within and across regions. In some domains, there are clear exemplars that emerge in the literature, for example, Sweden has been seen as an ideal type for social and welfare spending (Freeman, Topel, & Swedenborg, 2008) while Finland has been hailed as a model for emulation in education (Takayama, 2010).

Health, on the other hand, has defied a neat exemplar and attempts to rank health systems have been seemingly met with more opposition than usual (Jamison & Sandbu, 2001; Noy & Sprague-Jones, 2016). The literature recognizes that especially in health, there is no "one size fits all" and that countries with private and public systems and those in between have each been successful in promoting efficiency and equity in health. While the cases discussed in this article are not argued to be representative of other countries, they are instructive. For example, we may expect policymakers and experts in middle income countries with historically low to middle state autonomy and capacity in health to engage in model naming logics akin to those discussed in Peru, though perhaps especially those with high ethnic including indigenous diversity.

The issues that policymakers and experts raise when they do invoke policy models, and how and why they mobilize positive versus negative comparisons as well as what axes of similarity they look to in terms of identifying potentially useful models, including proximity, may track to other cases. In particular, while the health literature has focused on health outcomes and disparities as indicators of system performance, my data suggests that policymakers and other key actors look to political and cultural factors even more often—situating the health system and possible models in their broader national context. Future studies should examine whether and how these findings apply to health models in other global South countries, and across other sectors.

As such, understanding the models that experts and decision makers look to as well as which features they prioritize provides important information about the ideational background of policy process and change. It is these traits and attributes that policymakers may seek to work towards in their own national policies and priorities. Information about model countries in health—and what makes them model countries—provide insight about how decision makers anchor their understandings in the policy space, variation in models, and the ways in which experts situate and justify their understandings of health models to emulate regionally and globally.

CRediT authorship contribution statement

Shiri Noy: conceptualized the research, collected and analyzed the data, and wrote the manuscript.

Declaration of Competing Interest

The author declares that she has no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

I thank Joe Harris, Patricia McManus, and Tasleem Padamsee and for helpful conversations about and suggestions for this paper. I gratefully acknowledge funding for data collection from National Science Foundation grant SES-1029564.

References

Alcalde-Rabanal, J. E., Lazo-González, O., & Nigenda, G. (2011). Sistema de salud de Perú. *Salud Pública de México, 53*, s243–s254.
Baldwin, E., Carley, S., & Nicholson-Crotty, S. (2019). Why do countries emulate each others' policies? A global study of renewable energy policy diffusion. *World Development, 120*, 29–45. https://doi.org/10.1016/j.worlddev.2019.03.012.
Bazeley, P. (2013). *Qualitative data analysis*. Practical strategies. Sage.
Beckert, J. (2013). Imagined futures: Fictional expectations in the economy. *Theory and Society, 42*(3), 219–240. https://doi.org/10.1007/s11186-013-9191-2.
Béland, D. (2009). Ideas, institutions, and policy change. *Journal of European Public Policy, 16*(5), 701–718. https://doi.org/10.1080/13501760902983382.
Béland, D. (2016). Ideas and institutions in social policy research. *Social Policy & Administration, 50*(6), 734–750. https://doi.org/10.1111/spol.12258.
Béland, D., & Orenstein, M. A. (2013). International organizations as policy actors: An ideational approach. *Global Social Policy, 13*(2), 125–143. https://doi.org/10.1177/1468018113484608.
Belló, M., & Becerril-Montekio, V. M. (2011). Sistema de salud de Argentina. *Salud Pública de México, 53*, s96–s109.
Belmartino, S. (2000). The context and process of health care reform in Argentina. In Reshaping Health Care in Latin America. A Comparative Analysis of Health Care Reform in Argentina, Brazil and Mexico. Ottawa: International Development Research Centre (pp. 27–46).
Blyth, M. (2002). *Great transformations: Economic ideas and institutional change in the twentieth century*. Cambridge University Press.
Brooks, S. M. (2005). Interdependent and domestic foundations of policy change: The diffusion of pension privatization around the world. *International Studies Quarterly, 49*(2), 273–294. https://doi.org/10.1111/j.0020-8833.2005.00345.x.
Carazo Salas, J. A. (2011). Interview. August 26, 2011. San Pedro, Costa Rica.
Carpenter, D. (2012). Is health politics different? *Annual Review of Political Science, 15*(1), 287–311. https://doi.org/10.1146/annurev-polisci-050409-113009.
Castro Quiroz, J. A. (2011). Interview. May 11, 2011. Lima, Peru.
Cetrangolo, O. (2011). Interview. June 21, 2011. Buenos Aires, Argentina.

Clark, M. A. (2002). Health sector reform in Costa Rica: reinforcing a public system. In Woodrow Wilson Center workshops on the politics of education and health reforms, Washington DC.

de Sousa Santos, B., & Rodríguez-Garavito, C. A. (2005). *Law, politics and the subaltern in counter-hegemonic globalization* (p. 1). Law and Globalization from Below: Towards a Cosmopolitan Legality.

Dobbin, F., Simmons, B., & Garrett, G. (2007). The global diffusion of public policies: Social construction, coercion, competition, or learning?. *Annual Review of Sociology, 33*(1), 449–472. https://doi.org/10.1146/annurev.soc.33.090106.142507.

Draude, A. (2017). The agency of the governed in transfer and diffusion studies. *Third World Thematics: A TWQ Journal, 2*(5), 577–587. https://doi.org/10.1080/23802014.2018.1470476.

Ebbinghaus, B., & Gronwald, M. (2011). *International policy diffusion or path dependent adaptation? the changing public private pension mix in Europe*.

Franzoni, J. M., & Voorend, K. (2011). Actors and ideas behind CCTs in Chile, Costa Rica and El Salvador. *Global Social Policy, 11*(2-3), 279–298. https://doi.org/10.1177/1468018111421296.

Freeman, R. B., Topel, R. H., & Swedenborg, B. (2008). *The welfare state in transition: Reforming the Swedish model*. University of Chicago Press.

Gautier, L., Tosun, J., De Allegri, M., & Ridde, V. (2018). How do diffusion entrepreneurs spread policies? Insights from performance-based financing in Sub-Saharan Africa. *World Development, 110*, 160–175. https://doi.org/10.1016/j.worlddev.2018.05.032.

Gerring, J. (2004). What is a case study and what is it good for? *American Political Science Review, 98*(2), 341–354. https://doi.org/10.1017/S0003055404001182.

Gieryn, T. F. (1983). Boundary-Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists. *American Sociological Review, 48*(6), 781. https://doi.org/10.2307/2095325.

Glanc, M. (2011). Interview. June 22, 2011. Buenos Aires, Argentina.

González, S., & Healey, P. (2005). A sociological institutionalist approach to the study of innovation in governance capacity Retrieved from. *Urban Studies, 42*(11), 2055–2069 http://www.jstor.org.denison.idm.oclc.org/stable/43197223.

Gonzalvez, G. (2011). Interview. May 12, 2011. Lima, Peru.

Gutiérrez, C., Romaní Romaní, F., Wong, P., & Del Carmen Sara, J. (2018). Brecha entre cobertura poblacional y prestacional en salud: un reto para la reforma de salud en el Perú. In Anales de la Facultad de Medicina (Vol. 79, pp. 65–70). UNMSM. Facultad de Medicina.

Haas, P. M. (1992). Introduction: Epistemic communities and international policy coordination. *International Organization, 46*(1), 1–35. https://doi.org/10.1017/S0020818300001442.

Hanefeld, J., & Walt, G. (2015). Knowledge and networks - key sources of power in global health: Comment on "Knowledge, moral claims and the exercise of power in global health". *International Journal of Health Policy and Management, 4*(2), 119–121 https://doi.org/10.15171/ijhpm.2015.25.

Immergut, E. M. (1992). *Health politics: Interests and institutions in Western Europe*. CUP Archive.

Interview with a consultant and academic (2011). June 17, 2011. Buenos Aires, Argentina.

Interview with an Inter-American Development Bank official (2011). June 16, 2011. Buenos Aires, Argentina.

Jacobs, A. M. (2009). How do ideas matter?: Mental models and attention in german pension politics. *Comparative Political Studies, 42*(2), 252–279. https://doi.org/10.1177/0010414008325283.

Jamison, D. T., & Sandbu, M. E. (2001). WHO ranking of health system performance. *Science, 293*(5535), 1595–1596.

Jasanoff, S. (2005). *Designs on nature: Science and democracy in europe and the United States*. Princeton University Press.

Jimenez Fonseca, E. (2011). Interview. September 21, 2011. San Jose, Costa Rica.

Kaasch, A. (2015). *Shaping global health policy: Global social policy actors and ideas about health care systems*. Springer.

Kuckartz, U. (2014). Qualitative Text Analysis: A Guide to Methods. Practice & Using Software London, UK: SAGE Publications, Ltd. London, UK: Sage Publications.

Kwon, H., & Kim, W. (2015). The evolution of cash transfers in Indonesia: Policy transfer and national adaptation. *Asia & the Pacific Policy Studies, 2*(2), 425–440.

Labonté, R., & Schrecker, T. (2007). Globalization and social determinants of health: Promoting health equity in global governance (part 3 of 3). *Globalization and Health, 3*(1), 7. https://doi.org/10.1186/1744-8603-3-7.

Leimgruber, M. (2012). The historical roots of a diffusion process: The three-pillar doctrine and European pension debates (1972–1994). *Global Social Policy, 12*(1), 24–44. https://doi.org/10.1177/1468018111431668.

Morgan, R., Ensor, T., & Waters, H. (2016). Performance of private sector health care: Implications for universal health coverage. *The Lancet, 388*(10044), 606–612. https://doi.org/10.1016/S0140-6736(16)00343-3.

Noy, S., & Sprague-Jones, J. (2016). Comparative dynamics of public health spending: Re-conceptualizing delta-convergence to examine OECD and Latin America. *International Journal of Comparative Sociology, 57*(6), 425–448. https://doi.org/10.1177/0020715216686821.

Noy, Shiri (2017). In *Banking on Health: The World Bank and Health Sector Reform in Latin America*. London: Springer International Publishing.

Noy, S., & McManus, P. A. (2015). Modernization, Globalization, Trends, and Convergence in Health Expenditure in Latin America and the Caribbean. Sociology of Development, 1(2), 321 LP – 346. https://doi.org/10.1525/sod.2015.1.2.321

Parodi, L. (2005). Evaluando los efectos del Seguro Integral de Salud (SIS) sobre la equidad en la salud materna en el contexto de barreras no económicas al acceso a los servicios. Retrieved from http://cies.org.pe/files/active/0/parodi.pdf

Robles Monge, M. (2011). Interview. October 21, 2011. San Jose, Costa Rica.

Rostow, W. W. (1990). *The stages of economic growth: A non-communist manifesto*. Cambridge University Press.

Rubinstein, A., Zerbino, M. C., Cejas, C., & López, A. (2018). Making universal health care effective in Argentina: A BLUEPRINT FOR REFOrm. *Health Systems & Reform, 4*(3), 203–213. https://doi.org/10.1080/23288604.2018.1477537.

Saenz Jimenez, L. (2011). Interview. October 5, 2011. San Jose, Costa Rica.

Salas Chaves, A. (2011). Interview. August 31, 2011. San Jose, Costa Rica.

Salinas Rivas, A. (2011). Interview. May 17, 2011. Lima, Peru.

Shiffman, J. (2014). Knowledge, moral claims and the exercise of power in global health. *International Journal of Health Policy and Management, 3*(6), 297–299 https://doi.org/10.15171/ijhpm.2014.120.

Soto, S. R. (2011). Interview. August 24, 2011. San Pedro, Costa Rica.

Steiner-Khamsi, G. (2014). Cross-national policy borrowing: Understanding reception and translation. *Asia Pacific Journal of Education, 34*(2), 153–167. https://doi.org/10.1080/02188791.2013.875649.

Steinhilper, E. (2015). From "the Rest" to "the West"? Rights of indigenous peoples and the western bias in norm diffusion research. *International Studies Review, 17*(4), 536–555.

Steven, D., & Bujones, A. K. (2014). The laboratory of development the impact of social policies on children in Latin. *Retrieved from* https://cic.nyu.edu/sites/default/files/lab_development_children.pdf.

Takayama, Keita (2010). Politics of externalization in reflexive times: Reinventing Japanese education reform discourses through "Finnish PISA Success". *Comparative Education Review, 54*(1), 51–75. https://doi.org/10.1086/644838.

Tilly, C. (1984). *Big structures, large processes, huge comparisons*. Russell Sage Foundation.

Tobar, F. (2011). Interview.

True, J., & Mintrom, M. (2001). Transnational networks and policy diffusion: The case of gender mainstreaming. *International Studies Quarterly, 45*(1), 27–57. https://doi.org/10.1111/0020-8833.00181.

Unger, J.-P., De Paepe, P., Buitrón, R., & Soors, W. (2008). Costa Rica: Achievements of a heterodox health policy. *American Journal of Public Health, 98*(4), 636–643. https://doi.org/10.2105/AJPH.2006.099598.

Vasallo, C. A. (2011). Interview. June 13, 2011. Buenos Aires, Argentina.

Velasquez Valdivia, A. (2011). Interview. May 26, 2011. Lima, Peru.

Vreeland, J. R. (Ed.). (2003). *The IMF and economic development*. Cambridge University Press.

Weyland, K. (2005a). The diffusion of innovations: How cognitive heuristics shaped Bolivia's pension reform. Comparative Politics, 21–42.

Weyland, K. (2005b). Theories of policy diffusion lessons from Latin American pension reform. *World Politics, 57*(2), 262–295. https://doi.org/10.1353/wp.2005.0019.

Weyland, K. (2009). *Bounded rationality and policy diffusion: Social sector reform in Latin America*. Princeton University Press.