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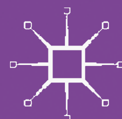
United Nations Research Institute for Social Development

social policy in a development context series

towards universal health care in emerging economies

opportunities and challenges

edited by Ilcheong Yi



Social Policy in a Development Context

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Social Policy in a Development Context is a series which places social policy at the centre of research while maintaining UNRISD's unified approach to social development. The series provides a new and exciting contribution to the literature in economic development and social policy. In economic development, social policy has been recognized as an integral part of development, but the literature often falls short of elaborating social policy for a unified approach to economic and social development. In social policy, analysis has concentrated mainly on European and North American countries, and studies on developing countries often lack comparative rigour. The bridge between economic development and social policy will not only contribute to the academic research but also inform the policy debate at the international and national levels.

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Ilcheong Yi
Editor

Towards Universal Health Care in Emerging Economies

Opportunities and Challenges

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Foreword

Whether social services and protection are available to all people, or governments choose to take a more targeted approach to social policy, has been one of the most vibrant development debates over the past three decades. The United Nations Research Institute for Social Development (UNRISD) has long been on the front line of the struggle for more inclusive and sustainable development, promoting not only universal approaches but also the concept of transformative social policy—that is, state intervention that, in addition to providing social protection, directly affects redistribution, production and reproduction.

An autonomous research institute within the United Nations system, UNRISD provides critical analysis and evidence on the political forces and institutional drivers that shape social policy. UNRISD has paid particular attention to the comparative effectiveness of universal and targeted social policy and programmes, and how they help to reduce poverty and inequality in developing countries. This has led us to critique targeted approaches in social service provision based on evidence that, compared with universal approaches, targeting and selectivity are less cost-effective and sustainable, and are more likely to infringe human rights and weaken social solidarity. UNRISD research highlights the importance of universal social policy as both a means and an ends: a way of tackling persistent poverty and growing inequalities, and of reaffirming the values and goals of universality set forth in international agreements from the Universal

Declaration of Human Rights to the Millennium Development Goals and, most recently, the 2030 Agenda for Sustainable Development which also calls for the transformation of our world and for no one to be left behind.

Universalism in social service provision is defined and redefined by interactions between diverse political forces and through policy processes at different levels of governance. Although recent international agreements, notably the 2030 Agenda, have swung the pendulum back towards universal social service provision, national-level forces (such as the imposition of austerity measures in many countries) strongly shape the definition, parameters and practice of universalism in social policy. Research that is both strategic and practical, moving beyond polemical debates to concrete evidence-based recommendations, can help countries identify the institutions, actors and processes conducive to more inclusive and sustainable forms of universal social service provision.

When designing this research project with partners, UNRISD selected eight countries at different stages of universalization in their health sectors. These countries, characterized as 'emerging economies', attract academic and policy interest due to their economic performance regionally and globally. While academic research on their economic dynamics is abundant, research on how they have designed and implemented social policies, and how the latter interact with economic policies and political change, is relatively scarce. This book helps improve understanding of the dimensions, policy linkages and drivers of universalization of health care, and, through the study of countries along a broad spectrum of universalization in their health care systems, demonstrates that there are diverse pathways towards universalism in health care.

Although it is almost impossible, and certainly not desirable, to distil general lessons that fit all socio-economic and political contexts from these case studies, there are still some common points that are indicative of strategies to achieve more inclusive and sustainable universal social policy. These include the necessity of creating mutually reinforcing mechanisms between social movements and governments as a new form of politics of welfare expansion; the importance of continuously advocating for and strengthening universality; and the imperative to engage and

incentivize the private sector to work in the public interest. These all pose both challenges and opportunities to policy stakeholders involved in health governance, which itself is a sphere of negotiation, compromise and consensus building around fundamental values, key policies and political coalitions. Learning lessons from any developmental experience is not an easy task. The first step is to recognize that institutions and policies are context-specific. We expect this book and its case studies to inspire readers and policy makers in developing countries to cast off 'one-size-fits-all' recommendations, and to establish their own specific strategies, institutions and policies for universalization.

UNRISD would like to take this opportunity to thank the Hospital do Coração (HCor) and the Ministry of Health of the Federative Republic of Brazil (through the Institutional Development Program of the Unified Health System/PROADI SUS) for generous financial support for this project. The research project was conceived in partnership with the World Social Forum on Health and Social Security and the Public Health Movement in Brazil, and was inspired by the 1st World Conference on the Development of Universal Social Security Systems held in Brasilia in 2010. Armando de Negri Filho's knowledge and experience of the World Social Forum on Health and Social Security, Brazil's Public Health Movement, the Innovations Laboratory at HCor, and a diverse range of universalization processes across the world were instrumental in the design and implementation of the project. Ilcheong Yi and Kelly Stetter (UNRISD), Olive Cocoman (now at the World Health Organization) and Elizabeth Koechlein (now at AcademyHealth) made tremendous contributions to this project and resulting book, with their roles ranging from project design and coordination to writing and editing. Elena Camilletti, Benedict Craven, Anna Dadswell, Rewa El Oubari, Louis Vargas Falbaum, Subhash Ghimire, Susanne Gjonnes, Roosa Jolkkonen, Sarah Parker, Claire Peterson, Giulia Scaroni, Saskia Sickinger, Portia Spinks, Emilia Toczydlowska and Barbara Walter, all formerly of UNRISD, provided research and other assistance at various stages. Professor Krishna D. Rao, Department of International Health, Johns Hopkins University, reviewed the entire manuscript and his valuable comments improved the quality of this book. UNRISD

appreciates the contributions and support of many other people who cannot be named here, particularly anonymous chapter reviewers.

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Paul Ladd
Director, UNRISD

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List of Abbreviations and Acronyms

AD	*Acción Democrática* (Democratic Action party, Venezuela)
AFC	Asian financial crisis
AIDS	Acquired immunodeficiency syndrome
ANC	African National Congress (South Africa)
ARV	Antiretroviral
Asabri	*Asuransi Angkatan Bersenjata Republik Indonesia* (Indonesian armed forces' social insurance)
Askes	*Asuransi Kesehatan* (Indonesian health insurance for civil servants, retired civil servants and retired military personnel)
Askeskin	*Asuransi Kesehatan bagi Keluarga Miskin* (Indonesian health insurance for poor households)
BPJS	*Badan Penyelenggara Jaminan Sosial* (Indonesian social security implementing agency)
BRICS	Brazil, Russia, India, China and South Africa
CAP	*Caixas de Aposentadorias e Pensões* (Retirement and Pension Credit Unions, Brazil)
CCP	Chinese Communist Party
CCT	Conditional cash transfer
CGU	*Controladoria Geral da União* (Comptroller General of the Union, Brazil)
CMS	Cooperative Medical System

COPEI *Comité de Organización Política Electoral Independiente* (Christian Democrat Party, Venezuela)
CPMF *Contribuição Provisória sobre Movimentação Financeira* (Provisional Contribution on Financial Transactions, Brazil)
CSMBS Civil Servant Medical Benefit Scheme (Thailand)
CSO Civil society organization
CUPs Contracted units for primary care
DA Democratic Alliance (South Africa)
Dasperi *Dana Kesejahteraan Pegawai Negeri* (Indonesian civil servants' welfare fund)
DoH Department of Health (South Africa)
DP Democrat Party (Thailand)
DRC Development Research Centre of the State Council (China)
DRG Diagnosis-related group
DSP Developmental state paradigm
DWS Developmental welfare state
EMI Employee Medical Insurance
EU European Union
GDP Gross domestic product
GFC Global financial crisis
HIC High-income country
HIV Human immunodeficiency virus
HLEG High-level expert group
IAP *Institutos de Aposentadorias e Pensões* (Institute of Pensions and Retirement Benefits, Brazil)
ID Identity
IDR Indonesian Rupiah
IDSS *Índice de Desempenho da Saúde Suplementar* (Supplementary health care performance index, Brazil)
IDSUS *Índice de Desempenho do SUS* (SUS performance index, Brazil)
IDUs Intravenous drug users
ILO International Labour Organization
IMF International Monetary Fund

IMR	Infant mortality rate
INAMPS	*Instituto de Assistência Médica da Previdência Social* (National Institute of Medical Assistance and Social Welfare, Brazil)
INGOs	International non-governmental organizations
INR	Indian Rupee
IVSS	*Instituto Venezolano de los Seguros Sociales* (Venezuelan Social Security Institute)
Jamkesmas	*Jaminan Kesehatan Masyarakat* (Indonesian health security scheme for the poor)
Jamsostek	*Jaminan Sosial Tenaga Kerja* (Indonesian workers' social security)
JPS	*Jaring Pengaman Sosial* (Indonesian social safety net programme)
KPI	Key performance indicator
LAPOP	Latin American Public Opinion Project
MDGs	Millennium Development Goals
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MHI	Mandatory health insurance
MMR	Maternal mortality rate
MoF	Ministry of Finance (China)
MoH	Ministry of Health (China)
MOPH	Ministry of Public Health (Thailand)
MPs	Members of Parliament
MSAS	*Ministerio de Sanidad y Asistencia Social* (Ministry of Health and Social Assistance, Venezuela)
MSDS	*Ministerio de Salud y Desarrollo Social* (Ministry of Health and Social Development, Venezuela)
MWS	Medical Welfare Scheme (Thailand)
NAC	National Advisory Council (India)
NCMS	New Cooperative Medical Scheme (China)
NFHS	National Family Health Survey (India)
NFSA	National Food Security Act (India)
NGOs	Non-governmental organizations
NHI	National Health Insurance (South Africa)
NHS	National Health Service (UK)

NHSB	National Health Security Board (Thailand)
NHSO	National Health Security Office (Thailand)
NRHM	National Rural Health Mission (India)
OECD	Organisation for Economic Co-operation and Development
OPEC	Organization of Petroleum Exporting Countries
PDPs	*Parcerias para o de Desenvolvimento Produtivo* (Partnerships for productive development)
PDS	Public Distribution System (India)
PDVSA	*Petróleos de Venezuela SA* (state oil company, Venezuela)
PHC	Primary health care
Poskesdes	*Pos kesehatan desa* (village health post, Indonesia)
Posyandu	*Pos pelayanan terpadu* (integrated health post, Indonesia)
PPP	Purchasing power parity
PSSOP	Public sector system of provision
PT	*Perseroan Terbatas* (Indonesian limited liability company)
Puskesmas	*Pusat kesehatan masyarakat* (community health centre, Indonesia)
Pusling	*Puskesmas keliling* (mobile health centre, Indonesia)
Pustu	*Puskesmas pembantu* (community health subcentre, Indonesia)
RMB	Renminbi (Chinese yuan)
RSA	Republic of South Africa
RSBY	*Rashtriya Swasthya Bima Yojana* (health insurance scheme, India)
RTE	Right to education
SA	South Africa
SARS	Severe acute respiratory syndrome
SDGs	Sustainable Development Goals
SDR	Age-standardized Death Rate
SJSN	*Sistem Jaminan Sosial Nasional* (Indonesian National Social Security System)
SRM	Social risk management
SRS	Sample Registration System (India)
SSA	*Sarva Shiksha Abhiyan* (Education For All movement, India)
SSS	Social Security Scheme

STD	Sexually transmitted disease
SUDS	*Sistema Unificado e Decentralizado de Saúde* (Unified Decentralized Health System, Brazil)
SUS	*Sistema Único de Saúde* (Unified Health System, Brazil)
Taspen	*Tabungan Asuransi Pegawai Negeri* (Indonesian Civil Servant Insurance Savings)
TB	Tuberculosis
TFR	Total fertility rate
TRT	Thai Rak Thai (political party)
UCS	Unified Coverage Scheme (Thailand)
UFMR	Under-five mortality rate
UHC	Universal health coverage
UNDP	United Nations Development Programme
URBMI	Urban Resident Basic Medical Insurance (China)
USD	United States Dollars
VHCS	Voluntary Health Card Scheme (Thailand)
VHI	Voluntary health insurance
WHO	World Health Organization
WRA	Welfare regimes approach

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1

Introduction: The Universalization of Health Care in Emerging Economies

Ilcheong Yi, Elizabeth Koechlein and Armando de Negri Filho

Ensure Healthy Lives and Promote Well-Being for All at All Ages

One of the most distinctive features of the United Nations General Assembly resolution, *Transforming our World: 2030 Agenda for Sustainable Development*, is its emphasis on equality as a key principle to frame the Sustainable Development Goals (SDGs) and targets. Goal 3, to "ensure healthy lives and promote well-being for all at all ages" (UN General Assembly 2015: 16), promotes healthy lives for *all* through investment in health systems and sets a specific target for universal health coverage (UHC). The health-related SDGs denote a significant departure from the earlier Millennium Development Goals (MDGs), which focused on interventions benefiting specific subpopulations, such as children under five years of age and pregnant women, and specific conditions like human

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immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and malaria. While targeted health interventions have been crucial for saving lives, the ad hoc and responsive nature of such programmes has proven insufficient in light of recent devastating epidemics such as the Ebola crisis. The SDGs, particularly Goal 3, are a global response to the call for a shift from targeted, residual and specific health interventions towards universal and system-wide approaches. This is echoed throughout international and national governance, and by researchers, policy makers and health practitioners.

In the history of development discourse and practice, however, universal and system-wide approaches to achieve comprehensive health care service for all are not new. In many countries, such as the UK, France, Germany and Sweden, the "universal" in health care provision has been evolving as a key element of universal social policy since the Second World War. The neoliberalism which became dominant in ideas and practice from the late 1970s eroded many transformative and solidaristic aims embedded in development policies, including health. A recent shift in international and national discourse around health systems has once again brought universalism to the fore, with many developing and emerging economies pursuing universal health care with very diverse outcomes. This volume explores how eight selected emerging economies are moving towards universal health care, what accounts for their diversity in outcomes, and introduces theories and frameworks useful to understanding the experiences of these countries. This introductory chapter puts these political trends and theories in context.

Universalism and Neoliberalism in Health Care After the Second World War

In the process of building institutions for welfare states in industrially advanced countries, universalism was the dominant organizing principle to reduce poverty in society; the health systems in many of these industrially advanced countries were developed to cover the entire population.

This is in contrast to the "Poor Law-style"[1] systems that preceded universalism. Universalism as a guiding principle for social policies is undergirded by the idea that an entire population has a right to be the beneficiary of a social service or benefit (Mkandawire 2005). In the case of universal health care, this generally means accessibility, coverage, adequate services, rights and entitlements and "protection from the social and economic consequences of illness" (Stuckler et al. 2010: 5) for the entire population. The use of the term "coverage" rather than "care", as in the case of "universal health coverage" of SDG 3.8, generally denotes that resource constraints in some contexts may inhibit the ability of countries to achieve de facto, rather than de jure, full health care (Stuckler et al. 2010).

In particular, in the period from the end of the Second World War up until the early 1970s, the understanding of the welfare state as an institutional arrangement for solidarity and social security was dominant over targeted systems designed to relieve poverty in many advanced welfare states, particularly in those countries categorized as Scandinavian welfare states. Welfare states were understood as an institutional expression of egalitarianism and solidarity rather than a simple collection of social policy programmes (Kildal and Kuhnle 2005). Different rules and regulations for eligibility, access, appropriateness and distribution, which are themselves the result of compromises and overlapping consensus between competing movements and policies, resulted in a variety of universalism in welfare programmes.

Since the early 1970s, slow economic growth, high unemployment and demographic changes associated with ageing populations have put persistent fiscal strain on the welfare states of industrial democracies. Since the 1980s, neoliberal ideas have become the mainstream political ideology in many, if not all, developed and developing countries. Marketization, privatization, liberalization, commercialization and financialization crept into policies and institutions across various sectors in developing and developed countries.

The welfare states of advanced industrialized democracies such as the USA, the UK and many European countries have also introduced competition into the health sector. Under the Thatcher administration

[1] The "Poor Laws" were an early system of targeted poverty relief in England and Wales that lasted until the emergence of the modern welfare state after the Second World War.

in the 1970s, the National Health Service (NHS) of the UK transformed from a public service for sick patients into a public system of purchasers (health authorities) and providers (hospitals, community health services, and specialists) competing over consumers (Light 2003). Although universal coverage was retained, this public system based on "managed competition" reduced universality in terms of the availability, accessibility, accommodation and acceptability dimensions by undermining public health. This brought about negative consequences in equity and efficiency, with enormous costs for regulation and monitoring (Light 1992), and by 1997 political support for managed competition had been abandoned. However, the trend of managed completion and commercialization within health systems had spread from the USA not only to the UK, but also to most of Europe and some developing countries with support from the International Monetary Fund (IMF) and the World Bank (Light 2003).

Beyond Europe, many postcolonial governments in sub-Saharan Africa during the "nationalist" phase of the 1960s to the early 1970s incorporated the idea of universal social policies as a key element of state-centred policy and planning for nation building. This was based on the belief that economic development would increase the number of formally employed workers, consequently bringing all workers into the formal labour force and within the reach of formal social security.[2] Neoliberalization destroyed many of these transformative social policies instituted during the 1960s, 1970s and 1980s in sub-Saharan Africa (Adésínà 2009). Since the late 1970s, health policies have been strongly influenced by a combination of forces which can be conceptualized as "commercialization". These forces include the:

> provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance. (Mackintosh and Koivusalo 2005: 3)

[2] Kabeer (2014), Adésínà (2007), Adésínà (2009).

In many developing countries, health services for the poor, which had been provided free of charge or at a subsidized price, were significantly reduced in response to neoliberal assault. Private insurance schemes, often subsidized by public funds, were introduced or expanded, hollowing out the public system of health provision. The poor were increasingly excluded from both public and private health care systems (Grosh 1994). Commercialization has caused, in many countries, a shift away from universalism to the selectivity, stagnation or deterioration of health outcomes.

Contestation in Health Care Provision

Neoliberalism takes diverse forms, but in health systems, it generally signifies a shift from the public sector to the private sector in regulatory roles and functions, property rights over health service facilities, and health service delivery.[3] Many existing public health institutions are dismantled and replaced with market-led or commercialized models of health care, with essential services accessible only to those able to pay. In such systems, investment in and production of health care services are for income or profit and are financed by individual payment and private insurance (Mackintosh and Koivusalo 2005).

Confrontation between neoliberal reformers and advocates for health care based on the values of solidarity and universalism in social policy, however, continues to take place in both developed and developing countries. Contestation and compromise between adherents of diverse organizing principles between the extremes of market-fundamental neoliberalism and solidarity-based universalism continue to shape policy outcomes.

The complexity of the health sector and the preponderance of stakeholders involved make the contestation over health care distinctive from other social policies. For instance, the debates surrounding the universalization of the health care in many national contexts feature entrenched concerns about the cost of a coordinated financing system, loss of power within the medical profession, the feasibility of standardized universal

[3] Mytelka and Delapierre (1999), Scholte (2005), Mackintosh and Koivusalo (2005).

health care to meet diverse needs of clients and patients, and fears about quality of care, among other ideological concerns (Light 2003).

Contestation over health policy is also distinctive at the global level, and has played a significant role in moderating the shift away from universalism in national health sectors. Since the Second World War, numerous international treaties, conventions and declarations on health have been established to emphasize the importance of comprehensive coverage of health care services that are linked to human rights. One such major global initiative was the Alma-Ata Declaration at the International Conference on Primary Health Care in 1978. Defining health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO 1978: 2), the declaration claims health as a fundamental human right, a social goal and an economic imperative. It effectively pushed the meaning of universal health care beyond population coverage to emphasize the importance of the level of benefits through the assertion that people are entitled to be well and to have a certain quality of life above and beyond their right to receive medical treatment when they are sick (Navarro 1984).

Since Alma-Ata, even in the midst of neoliberal reforms in the health sector, there has been a broad consensus on the right to health, at least rhetorically, and a trend to link positive health outcomes with inputs broader than the health sector. Even the World Bank, a leading international agency historically notable for neoliberal ideology, has emphasized the importance of improving health systems. The World Bank expanded social sector spending on health, nutrition and population services in the "liberal reform" years of the 1980s and 1990s, and subsequently adopted a more holistic approach to health policies in the 2000s (Ruger 2005).

The Universal Health Coverage Agenda: A Shift Towards Universalism?

The UHC agenda, unanimously adopted as a resolution by the UN General Assembly in December 2012 and embedded in many goals and targets of the 2030 Agenda for Sustainable Development is the manifestation of a shift in discourse and policies towards expanding health care to

more people. The emphasis of the UHC agenda is once again on health systems and prevention. This agenda has in part arisen as an alternative to the many disease-specific programmes that have proliferated and developed ad hoc, often funded by major philanthropic organizations, in response to specific crises and epidemics (see Chap. 3), such as the recent Ebola outbreaks. While disease-specific programmes save lives, the focus on UHC coincides with the re-emerging apprehension that a health system without equal entitlement, eligibility, access and appropriateness of services and care is an economic and social danger even to those who enjoy relatively high quality health services, and does not contribute effectively to prevention.

The UHC agenda as much as other discourse on health care, involves continuous competition between diverse interpretations of universalism, on the means of implementation and on the policies to achieve desired outcomes. Due to a cultivated ambiguity sensitive in this discourse, the UHC agenda does not offer clear views about the degree of government involvement in the funding or provision of health care. This vagueness may allow "different mixes of public/private provision and responsibility, different degrees of market or central planning, and different forms of financing, organization and management of local or national responsibilities" (MacGregor Chap. 3: 79).

This ambiguity implies that realizing the aspiration of the UHC agenda[4] involves ongoing struggles over institutions and policies affecting the nature of dimensions of social welfare within and beyond the health sector, particularly as there are many factors that impact on the health of populations that do not fall within the typical purview of a health sector. The field of health has been the space for some of the most emotionally and politically charged battles in recent decades, the outcomes of which are of literal vital importance to many. UHC, as an agenda to drive discussion under a set of normative but polysemic principles, allows for competing ideas, interpretations and policies to coexist under its umbrella; this only intensifies these battles.

[4] The aspiration for UHC: "universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective, and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population" (UN General Assembly 2012).

Universal Health Care in the Context of Social Policy Debates

Universal health care connotes that the state has an obligation to look after the health care of its entire population. In this sense, a universal health system is different from those that are corporatist—applying only to those employed and financed through contribution—and liberal or residual—those that target the poor (see Chap. 3). A truly universal and sustainable health system also addresses the social, economic and political determinants of health such as poverty, inequality and unemployment. Positive health outcomes are contingent on structural factors broader than health interventions, thus a truly universal health system is one embedded within equitable, inclusive and just societies (Navarro 1984).

The concept of universalism is not straightforward. In social policy debates, a universal approach has long been juxtaposed with a selective, or targeted, approach. However, universalism is not simply the opposite of selectivity, as Susanne MacGregor explains in Chap. 3. There can be positive selectivity, where the needs of certain categories, groups and territories are met (Anderson and Ytrehus 2012) and negative selectivity, which is principally means-testing for the purposes of exclusion (Vabø and Szebehely 2012). A "sophisticated universalism is sensitive to diversity" (Vabø and Szebehely 2012: 123). MacGregor further explains:

> Titmuss had earlier warned against over-simplifying the distinction between universal and selective (or targeted) services (Abel-Smith and Titmuss 1987). These have many forms, he observed, and selective services can play a role within a universalistic system. Marshall (1965) distinguished between universal programmes that guarantee a social minimum and those that strive to provide a social optimum. Targeting, by contrast, is when the scope of beneficiaries is more restrictive. More recently, Mkandawire (2005) noted that policy regimes are hardly ever purely universal or purely based on targeting—most are hybrids. (MacGregor Chap. 3: 66)

The diverse outcomes of countries moving towards universal health care demonstrate that the achievement of UHC, like the universal provision of other services, is more about politics, institutions and policies than

about gross domestic product (GDP). The interactions between divergent movements underpinned by ideas that range from neoliberalism to human rights result in the unique institutions and policies constituting welfare states, including their health systems. These interactions are found at multiple levels of political economy—global, regional, national and local, and in various policies within and outside the health sector.

Health sectors are fluid hybrids of public and private sectors, reflecting the changing balance of power between contending movements and trends through interactive processes of public and private responses to shifting economic opportunities and incentives associated with health issues (Polanyi 2001; Block 2008). Understanding the context of universalizing health care in different countries, therefore, requires interrogating intricate connections between political, economic and social factors around health issues within and outside the health sector and at various levels of governance.

Ben Fine's approach in Chap. 2 offers a comprehensive analytical and explanatory framework for research on the globalized and neoliberal context of health systems. Fine uses the "public sector systems of provision (PSSOPs)" approach for situating the study of social policy within its contemporary neoliberal context. This approach, an alternative to the welfare regimes approach (WRA), which Fine argues is still based on post-war realities, explains the diversity of developed and developing countries' welfare states in their responses to the varied impacts of financialization. Financialization is not only the ethos of assaults on state expenditure for social policy, but is a major factor influencing social policy making at both systemic and detailed levels. Understanding uneven incidence and forms of financialization across social policy sectors is particularly important in explaining systemic changes in welfare provision or welfare regime, and identifying the different regime characteristics of sectoral programmes such as health and housing policies within the same country. For Fine, "each social policy programme within each country needs to be examined on its own merits, taking account of the factors and specificities involved" (Johnston 2013: 21).

Fine's approach emphasizes that social policy theory must accommodate a variety of structural determinants, and how they interact across agencies, processes, relations and institutions to give rise to a diversity of shifting outcomes within and across countries and sectors within a country. Understanding these structural determinants offers a valuable explanation of differences among specific sectoral programmes within social policy: health, education and housing. The PSSOP approach, unlike the WRA, is particularly sensitive to context specificity, limiting the danger of giving unduly homogenous or "one-size-fits-all" policy advice on temporally and spatially specific social policy programmes.

Understanding Universalism: Six Dimensions of Social Policy Programmes

In practice, the ideas and practices of social service provision compete with each other for weight and priority in the design and implementation of social policy programmes. Once implemented, these dimensions also serve as indicators for assessing the universality and impact of a programme. Each dimension plays an important role in whether a social policy programme can be considered universal.

Table 1.1 shows six dimensions of conventional social policy programmes, such as the provision of health care, which together are considered in the process of social policy programme design.

Entitlement

Entitlement is the legal relationship between the beneficiary and the social service or benefit. An entitlement is an "expectation with normative force" (Singer 1981: 88); that is, an expectation that one *should* or *ought* to receive social services or benefits; this is different from aspiration or desire. However, an entitlement does not equate to the actual receipt of benefits or services either. An individual or a household is entitled to a specific benefit or service when one has constitutional or legal rights to claim a specific social benefit or service (Lerner 1987). What matters in assessing

Table 1.1 Dimensions and indicators of social policy programmes

Dimensions	1. Entitlement	2. Eligibility	3. Access	4. Appropriateness	5. Distributive rules	6. Organizing principle
Key indicators	Presence of constitutional rights or laws	Nature of preconditions	Availability, accessibility, accommodation, affordability, acceptability	Size of benefits and service package	Stratified/flat rate	Institutional arrangement

Source: Author

universality in this dimension is the presence of legal means of realization of these rights to benefits or services without requirements on beneficiaries to do anything in return. It means that what matters to universalism is not only a clause promulgating the specific right (entitlement), but also a wide range of political and institutional tools to empower the beneficiaries to claim, access and defend their rights when the rights are not realized. In the cases of Thailand and Brazil, constitutional changes created conditions for the empowerment of civil society and social movements. These were vital for the passage or implementation of health schemes to achieve universal coverage (see Chaps. 4, 6 and 7).

Eligibility

Eligibility is related to qualifying conditions for beneficiaries. It involves qualitatively different criteria depending on whether eligibility is based on need (determined via a means test), on contributions by the insured or employers to the financing of the social insurance programme, on belonging to a specific social group or occupational category, or on citizenship (or residence) in the country (Korpi and Palme 1998). Individuals or households can be entitled to a particular benefit or service by virtue of who they are or what they do. What matters in assessing universality in this dimension is, therefore, the nature of criteria for beneficiaries rather than the actual coverage, which is assessed through the "access" dimension.

Eligibility is central to the definition of universality or universalism in social policy. Eligibility in universalism refers to social service provision to all regardless of gender, race, region, age, health status, income or wealth: universal eligibility. Universal *eligibility* in health care means that all individuals are allowed treatment. This is not same as universal *coverage*, because under universal eligibility, some portion of the population may not get access to health services for reasons other than their eligibility status. This may be to the result of barriers such as distance, lack of financial means and information or discrimination. In Brazil, Thailand and China, different health schemes have different eligibility, and UHC is achieved not by a single scheme but by the system as a whole, composed of various schemes with different eligibility criteria.

Access

Access is to what extent beneficiaries can consume or use social services and benefits. Universal entitlement or eligibility does not always lead to a high level of utilization of welfare services. The latter often depends on enabling factors which enhance access. Access-enhancing factors involve a set of relationships, or more specific areas of "fit" between beneficiaries and the welfare programmes. There are five main relationships that enhance access in health systems through relationships between service and beneficiary:

1. *Availability:* The Relationship between the volume and type of existing health services and the beneficiaries' volume and types of needs is *availability*.
2. *Accessibility:* The relationship between the location of health service delivery and the location of beneficiaries is *accessibility.*
3. *Accommodation:* The relationship between the manner in which the delivery of health services are organized to meet the demands of beneficiaries (including appointment systems, hours of operation and channels of enquiry), the beneficiaries' ability to accommodate to these factors and the beneficiaries' perception of the appropriateness of these factors constitute *accommodation.*
4. *Affordability:* The relationship between cost, consisting of health service prices and the providers' insurance or deposit requirements, and the beneficiaries' income, ability to pay and existing social insurance schemes constitute *affordability.*
5. *Acceptability:* Beneficiaries' attitudes to the personal and practice characteristics of health service providers determine the *acceptability* of health care services delivered to the population (Penchansky and Thomas 1981).

A programme which is claimed to be universally available may not be always universally accessible or affordable due to the lack of a specific "fit" between providers and users. The absence of health service facilities in a remote area or high user fees mean that a universally available health service *in theory* may not be universal in terms of accessibility or affordability.

The cases of Brazil and Thailand demonstrate that the expansion of service provision through an increased number of health facilities in rural areas can contribute to expanding health coverage, and enhancing the utilization rates of the population, particularly the poor (see Chaps. 5 and 7).

Appropriateness

The dimension of appropriateness relates to the benefit-level principle, that is the question of to what *extent* benefits and services should be provided. National governments and international organizations adopt various, albeit sometimes vague, standards in social policy programme design to determine benefit levels for social services in different contexts. Standards range from a means-tested minimum through middle-class standards to the standards of living enjoyed by rich or privileged citizens.[5]

Quality in the health care sector is particularly important in the context of the coexistence of public and private health service provision. A relatively low quality of public service, frequently provided by tax-financed health services with little or no co-payment, in comparison with high-quality provision in private health services is common across developing countries. This dichotomy is examined further in the cases of Brazil, Thailand and China. Although the tax-financed or subsidized public programmes of these countries are pro-poor, they may pose longer-term problems to public health services if they lose broad national support due to low quality. This is especially true when publically financed services are perceived to be "second-tier" for low-income groups. Brazil and Thailand confront this challenge to their Unified Health System (*Sistema Único de Saúde,* SUS) and the Unified Coverage Scheme (UCS), respectively. Maintaining services at a quality level sufficient to mobilize political and consumer support is central to developing these programmes further (see Chaps. 4, 5, 6 and 7). The Thai and Brazilian cases also show the importance of changing public perceptions of health care. Understanding health care as a citizen's right is crucial in the process of universalization. Harnessing the power of public perception can lead to feelings of ownership, and the population will be more likely to express their opinions over how health care should be provided.

[5] Tawney (1952), Esping-Andersen (1990), Korpi and Palme (2003).

Distributive Rules

This perennial question of appropriate benefit levels is closely related to the social policy dimension on the distributive rules of benefits. These rules can be roughly categorized into flat rates or stratified systems. Distributive rules of benefits are redistributive mechanisms, and consequently have a significant impact on the reduction of poverty and inequality if designed progressively (Palme 1990; Korpi and Palme 1998).

Organizing Principle

The last dimension of social policy is related to its organizing principle, often understood as the political values or ideologies around which social policies are constructed and framed. Organizing principles are often a system of value hierarchy, which defines the interests and policy priorities of different societal groups (Freeden 2006). To what extent the public should assume responsibility for welfare and social services, and how to distribute resources are central to determining the level of universality in this dimension. Values and ideologies are often brought into policy debates in the form of policy principles, designs and means of implementation, which impact on peoples' well-being and utility calculations through welfare programmes (Kildal and Kuhnle 2005). Those with equity and solidarity at the core of their value hierarchy system tend to be closely associated with policies and institutions of progressive redistribution of resources for those services. Redistribution is often a litmus test in determining values and ideology, but is frequently excluded from assessments of the universality of social services. This is important because redistribution affects not only economic and social outcomes, but also the sustainability of universal social service programmes through its impact on political mobilization.

Considering the possibility of various interpretations of universalism across these six dimensions, universalism may best be considered as "an ideal, a vision and a goal serving as a rallying call and aid to mobilization" (MacGregor, Chap. 3: 65), whose nature and contents are shaped by struggles between competing movements and policies over the goals and

purposes of social policy and the roles and functions of social policies as a result of these struggles. The actual outcome of the programmes established with this ideal is inevitably as diverse as is the process of moving towards more universal outcomes in these dimensions.

Learning from the Experiences of Eight Emerging Economies

Neoliberal trends have had a varied impact on coverage within and across different countries. Twenty low- and middle-income countries managed to maintain, and in some cases achieve, health coverage greater than 90 percent of the population[6] during and following the era of widespread neoliberalism and corresponding pressure to commercialize health care services (Stuckler et al. 2010). Additionally, many health systems that saw a reduction in coverage during neoliberalism have made significant gains in more recent decades, while others continue to struggle. What accounts for this diversity? How have some low- and middle-income countries successfully maintained or even expanded health coverage while others have not? How are the benefits of expanded health coverage distributed?

To explore these questions in context, this volume presents eight selected countries in various stages of universalizing their health systems, most of which are emerging economies. "Emerging economies" or "emerging markets" are known as such for their notable economic performance or influx of capital. In the last few decades, these countries have undergone rapid and significant changes in their political systems as well as in their social and economic policies and institutions. Such changes shape their unique health systems. In these countries, pathways to UHC include, but are not limited to, "financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (SDG 3.8 in UN General Assembly 2015). These pathways are different from those of the industrially advanced countries after the Second World War, even

[6] Stuckler et al. (2010) define this in terms of access to verifiable health services such as skilled attendance at birth and health insurance.

though industrially advanced economies are often held up as a blueprint. Thus, it is important to document and understand the unique processes leading to the universalization of health care in these countries to better understand their outcomes (UN General Assembly 2015).

The countries in this volume have emerged as significant players in international health governance through contributions to global health financing, capacity building, access to affordable medicines and the development of new tools and strategies. Their experiences with health system development and alternative approaches to improving health outcomes offer valuable lessons for developing countries (GHSi 2012). Although each context is unique, these cases highlight a number of points: that health policies take shape from contestation; that they are more about political will than fiscal space; that institutional complementarity across multiple sectors, including the private sector, is crucial to the achievement of UHC; that global processes have national and local impact; and that context matters.

In the politics surrounding the expansion of health care coverage, social movements play a significant role in reshaping institutional politics. These movements are neither extra-institutional nor fade away even after their demands are channelled through democratic institutions such as political parties or the election process (Goldstone 2003). As MacGregor highlights (in Chap. 3), *the reinforcing interactions between social movements and governments,* and the drive for political stability and social order *form a specific politics of welfare expansion*, in particular of health care coverage in developing countries. The cases of Thailand (Chap. 4) and Brazil (Chap. 6) demonstrate that the political dynamics over expanding health coverage cannot be understood by only focusing on the institutional analysis of elections, courts, legislatures, executives or parties. One must also analyse the conduct and content from social movements and successful mobilization of empowered civil society. Universalization of health care in Brazil has been significantly influenced by selective initiatives, and at times spurred by grassroots movements, like the *movimiento sanitarista*, a social movement of health professionals, experts and unions.

Whether or not there are sufficient financial resources for health coverage tends to be subjective, determined by institutional capacity, political will and the politics of reform. In Chap. 4, Erik Martinez Kuhonta argues that in the process of democratization in Thailand, changes in political institutions, stronger

political parties, government stability and the empowerment of civil society played a significant role in the implementation of health care reform. UHC in Thailand was achieved just after the Asian financial crisis of 1997 damaged the Thai economy and the government's fiscal capacity. Kuhonta emphasizes that the reservoir of bureaucratic commitment and capacity, which had increased since the mid-1970s, helped to steer health reform through obstacles to its quick implementation. Rather than attributing the success of the reform of the Thai health system to a big bang approach, Chap. 4 emphasizes the importance of institutional capacity and reform strategies.

Chapter 13 also demonstrates the value of institutional capacity, politics and political will through the case of Venezuela, with a focus on the period of Hugo Chávez's presidency, where pro- and anti-expansion supporters competed with each other to set health care priorities. Julia Buxton asserts that economic instability, paired with "protagonistic democracy", contributed to the popularity of Hugo Chávez's plan to use oil wealth to finance social programmes. Despite available fiscal resources generated by oil exports, the Chávez government faced resistance to using these resources for social welfare and health spending from conservative opponents and vested interests, including the trade union movement and nominally social democratic parties. In Venezuela, it was not resource deficiency that posed a challenge to the expansion of coverage, but rather priority setting over which political forces competed. The contestation between the Chávez administration and others shaped the trajectory of social welfare provision in Venezuela. The lack of major institutional and economic policy change is in part a result of this contestation. Overall, the achievements were significant, particularly given the national crisis inherited by Chávez, but the sustainability of welfare initiatives without major institutional and economic policy reform will be continuously under threat.

Discursive struggles over universality in health care are crucial in the process of universalization: the results often shape the attitudes and political alliance of the public towards universal health care. These struggles also affect the interests and priorities of health stakeholders and health care quality. In South Africa, opponents of health system reform have argued that the system is already universal by focusing solely on legal entitlement. This focus has had a significant influence on middle-class voters. In Chap. 12, Rebecca Surender argues that contention between the proponents and opponents of the new National Health Insurance over the meaning of

universal health services and the role of the state continues to be a major bottleneck to progress in health system reform.

In India, social welfare schemes in the areas of work, education and food have been increasingly founded in accordance with a rights-based approach. There is, however, no such right to health and social insurance. The discursive deficiency in health care and social insurance as a means of implementation is reinforced by the underdeveloped health care system characterized by fragmented and residual health insurance, lack of financial protection, narrow coverage and inadequate benefit packages, and weak institutional capacity. This weak institutional capacity includes poor human resource management, an inefficient essential drug procurement system and lacking public health infrastructure (see Chap. 11).

Contestation over the meaning of universalism in the health sector can be also found in the case of Brazil. The Brazilian Constitution of 1988 makes clear that health is a right of citizens and the provision of health services is an obligation of the state. This arises from a shared belief in social inclusion and universalism. Additional factors, such as democratization, which fostered political competition for the median voter; institutional and organizational capacity to facilitate a decentralized system; and the creation of fiscal capacity through a comparatively high tax burden and macroeconomic stability, enabled the recognition of the right to health in the 1988 Constitution. Although there was overall support for UHC in the Brazilian congress, universalism in the constitution is still interpreted differently by proponents and opponents of a more comprehensive health care system. Based on wide recognition of the limitations of the system prior to the 1988 Constitution in terms of funding, levels of care, as well as disunity and fragmentation, conservative sectors, associated with vested interests and patrimonial politics, presented a narrow interpretation of universality in health care in Brazil (see Chaps. 6 and 7).

Tensions and competition within governments over the expansion of health care coverage are common across countries despite differences in their political regimes. In the cases of liberal, democratic South Africa and socialist authoritarian China (see Chaps. 12 and 9), financial ministries or treasuries tend to have a cautious view of the fiscal implications of the public provision of health care. Instead, they support the active involvement of private sector health care providers. Welfare ministries in these countries have a more proactive stance towards expanding health coverage.

Even among welfare-related government agencies in Thailand involved in implementing the UHC system, there are tensions and conflicts over the depth and scope of the 30 Baht Programme, particularly about how to allocate resources. The political will of the government and the capacity of the reformist forces to reallocate medical resources to the rural sector, where a majority of the 30 Baht Programme beneficiaries are concentrated, were weakened by a counter-reaction from conservative bureaucrats and urban doctors. Consequently, there was a reduction in the level of resources allocated to rural areas (see Chap. 4).

The cases of China, South Africa and Thailand demonstrate the importance of achieving consensus with key stakeholders and gaining the support of the wider central government, both of which are crucial if the momentum for far-reaching health reforms is to be maintained. In the cases of liberal democracy, a variety of political processes in both formal and informal politics create space for competition between ministries. In China, which has relatively little space for competition of ideas between ministries, international organizations and experts played a significant role in tilting the power balance in policy making towards proponents of expanding health coverage. Their role resulted in policy consensus within the government (see Chap. 9).

The configurations of institutions and policies for moving towards universalism in health, particularly those relating to the public and private sectors, are diverse across countries. Given the entrenched and deep-rooted market culture in the health sector in almost all emerging economies, there is a reliance on the private sector to meet health care needs at least in the immediate term. *Policy makers will need to identify strategies to meaningfully engage and incentivize the private sector* to achieve desired outcomes based on each health system's sectoral makeup. Central to this kind of strategy is addressing the structural causes of marketized and commercialized health systems, which generate obstacles and resistance to the universalization of health care. This is illustrated by the cases of China and Russia (Chaps. 9 and 10). In both of these cases, marketized and commercialized health service providers have increased health care costs and generated resistance towards reforms that expand coverage, while behaviour patterns of health care providers in the public sector generate irregularities and corruption. This was, and still is in some instances, a particularly serious issue in both China's and Russia's mixed systems of public and private provision, because it negatively affects the consumption of and support for the public provision of health care.

The dynamic interactions between actors and institutions in the public and private sectors must be taken into account from the perspective of health governance to address the structural causes of private sector resistance to universal health care. Health governance is the location of negotiation, compromise and consensus building for fundamental values, key policies and political coalitions. The unique histories, political contestations, social mobilizations and institutional challenges faced by each country create a set of distinctive obstacles and opportunities for the public sector in its attempts to be the facilitator of health care universalization. At the macro level, as Stein Ringen and Kinglun Ngok discuss in Chap. 8, failure to address structural causes results in the welfare system supporting the market economy rather than acting as an instrument for the transformation of the brute market into something qualitatively different.

At the micro level, Surender argues in Chap. 12 that garnering *the support and compliance of doctors is crucial in determining the eventual success and character of reforms* to expand health care provision in the context of the mixed system of private and public provision. Driven by ideological debate over whether health care should be a market or public good that is an obligation of the state, a substantial period of commercialization of health care in South Africa in the 1990s saw the size of the private sector increase drastically and entrench commercial elements in the public sector. In this context, it is particularly important to address the concerns of doctors around remuneration, resistance to local state control, increased workload, clinical autonomy, and “blame” for diminished quality of care.

All of the cases in this volume show that *the expansion of health coverage was accompanied by diverse forms of decentralization*, the drivers of which also vary according to particular national contexts. In South Africa, Brazil and Indonesia, decentralization was a part of the democratization process, while economic transition from a centralized, planned economy to a market economy led to decentralization in Russia and China. Health system reforms to expand coverage were heavily influenced by the nature of institutions and the role of major actors involved in the decentralization process. Structural and institutional issues in political, economic and social dimensions, such as regional disparities in terms of resources, the governance structure of resources, and political actors involved in central

and local politics, significantly affected the nature of health system reforms in design, financing and implementation and their outcomes in terms of health coverage.

In successful cases of achieving UHC, as seen in Brazil, decentralization was redefined and redesigned to facilitate the development of the health system in a way that expanded coverage. In contrast, the decentralization process in Indonesia was dominated by patrimonial, clientelistic politics, and resulted in a highly fragmented system of health insurance. Given this, Asep Suryahadi, Vita Febriany and Athia Yumna argue in Chap. 14 that the implementation of the national social security system to cover the entire population should proceed very cautiously and involve all stakeholders, including local governments, employers, employees and implementing agencies, as well as service providers, to develop a coherent national framework for the health care system.

Tax-financed health schemes which cover a significant share of the population that previously fell outside of the contribution-based insurance schemes *play a game-changing role in better health outcomes.* Tax-financed schemes indicate a departure from employment-based contributory health insurance to an "informal security" welfare regime reflecting the context of the vast majority of informal workers in developing countries (Gough and Wood 2004; UNRISD 2016). The UCS of Thailand and SUS of Brazil, which brought formal health care services to a majority of informal workers, had wide-ranging effects on health outcomes for the population as a whole through direct and indirect impacts on other systems of health provision beyond those schemes. In the case of Thailand, one such positive outcome was the development of a database of previously unavailable information on these workers, which could be used for other social protection schemes (see Chap. 5).

Understanding the diversity of developed and developing countries' welfare states in their responses to the varied impacts of neoliberal assaults on state expenditure for social policy requires a thorough examination of a variety of complex and context specific determinants of health systems. Knowledge of these structural and institutional determinants heightens the possibility to establish successful strategies for the universalization of health care in different contexts.

Concluding Remarks

The meanings of universalism within a health care system are socially constructed and contested. The historical evolution of social policy systems and the eight cases in this volume demonstrate that universalism in health is continuously redefined by the interactions between diverse political forces and through specific policy processes. Among these countries, those which have successfully expanded their health care system in terms of beneficiaries and services demonstrate that deliberative and participatory democratic practices provide an important space for resistance against exclusory health care systems and foster movements towards universal systems in their place. Institutional capacity both within and outside the health system is requisite for universal health care, and politics matter in shaping the institutions and policies of health systems. The presence of an effective and legitimate state, an efficient and meritocratic civil service, ideas of professionalism and professional ethics, and human rights and citizenship are crucial components to expanding a health system.

Moving towards a universal health care system is a long-term process involving both progress and regress. Reforms that promote universal access, improve quality of care and contain costs may achieve UHC; however, they may be insufficient to sustain UHC and further develop health care services if a society cannot eliminate poverty, reduce inequality and provide nutritious food, clean water, sanitation, shelter, education and preventive health care. To be successful, the expansion of a health system cannot happen in a vacuum; it must happen alongside concerted efforts to address the social and economic determinants of health. A health system is made universal and sustainable by balancing economic and social development in a way that creates synergies for generating and redistributing resources effectively, as well as empowering the poor and vulnerable.

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Part I

Analyzing Common Pressures and Diverse Social Policy Responses

2

The Continuing Enigmas of Social Policy

Ben Fine

Introduction

Social policy is extremely diverse across different countries, different programmes and over time and circumstance, yet this does not mean that it is free of common influences. In the contemporary world, these influences may include the role of globalization and neoliberalism and, most recently, the response to severe crisis. The presence and strength of aspirational goals such as meeting human rights and basic needs, alleviating poverty and so on also impacts social policies. This requires specification of what these controversial common determinants are, or mean, for they are themselves contested in how they are understood, whether they are positive for welfare policy, and more generally, how they allow for unavoidably heterogeneous outcomes.

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Disappointingly, if unsurprisingly, the vast bulk of the social policy literature, especially that concerned with framing the understanding and making of policy, derives from developed countries—and from Europe, in particular. Indeed, there has been a degree of conceptual imperialism as far as social policy is concerned, with the analysis and policies for developing countries following the putative lead of the developed. This raises the issue of how to learn from the literature without becoming its slave, and whether initiatives such as the Millennium Development Goals and the Sustainable Development Goals offer a way of escaping unduly predetermined ways of thinking.[1]

Based on a critical review of the literature, this chapter suggests an approach called "public sector systems of provision" (PSSOPs), which explains the diversity of developed and developing countries' welfare states in their responses to the varied impacts of financialization in the neoliberal era. This is done within a broad institutional context guided by a number of key threads drawing from a critical assessment of social policy literature.

Key Threads of PSSOPs

The first thread which appears unusual for framing social policy is to relate social policy to long-standing work on consumption (Fine 2013a). On the one hand, private, commercial consumption in terms of commodity-specific chains of provision, or systems of provision (Fine and Leopold 1993), can been seen as significantly distinct from one another, as is the case with food, fashion, energy, housing systems, etc. On the other hand, the huge expansion in the study of consumption across the social sciences in the decades of postmodernism has neglected *public* consumption. In a sense, it has been as if social policy simply does not exist when it comes to the study of consumption. There are good and understandable reasons for this. As soon as consumption becomes (recognizably) public, it tends to be redefined as something else, most notably as the welfare state or as social policy, putting it outside the realm of consumption studies.

[1] The Millennium Development Goals programme and similar are not covered in this chapter. See Lancet Commission (2010).

Nonetheless, while social policy does depart from market forms of consumption, the study of consumption does shed light on public provision. Without in any way reducing social provision to private consumption, this leads me to argue that social policy can be addressed in terms of what has been dubbed *public sector* systems of provision (PSSOPs).[2] As we see later in this chapter, the PSSOP approach can be seen to have a number of advantages, especially in light of the difficulties previously raised.

The second thread in my take on social policy is to emphasize the role of financialization, with its significance projected to new heights by the form and depth of the global crisis. Financialization is a new concept that derives predominantly from diverse heterodox traditions with equally diverse theoretical underpinnings, meanings and foci. No one can doubt that the direct and indirect impact of financial imperatives on social policy has been decisive over recent years. Yet, as far as the social policy literature is concerned, financialization might as well not exist. The reason for this, in part, is that the role of financial imperatives in the (re) making of social policy have long been studied not least in the light of previous crises and the ethos of assaults on state expenditure associated with neoliberalism. But do such long-standing analyses fully capture the extent to which finance has itself influenced, if not captured, the making of social policy at a systemic level as well as at the level of detail?

This is closely linked to the third thread, which is an antipathy to the welfare regimes approach (WRA) to social policy. The WRA has dominated social policy literature over the last two decades, and sorted welfare provision into a number of models or ideal types. Initially, this started with three models based on developed countries. The WRA has expanded this to include more of the advanced countries, as well as the East Asian, Latin American and so on, thereby addressing empirical anomalies or outliers as far as fit with the initial models is concerned.

While the WRA has allowed an enormous amount of informative empirical work to be undertaken, it has led to increasingly serious deficiencies, particularly in explanatory or theoretical content. It is incapable

[2] Fine (2002), Bayliss and Fine (2008), and Bayliss et al. (2013).

of explaining change, such as how a regime classified as a model of one sort becomes another. It fails to identify that different social policies should have the characteristics of different regimes within the same country, not least because it necessarily imposes undue homogeneity across diverse PSSOPs—whether by sector or by country. It is additionally incapable of offering policy advice, since policy is caught within its specified regime.

In short, welfare regimes have become something of a buzzword (and a fuzzword) in the social policy literature, not least with proliferating regimes as ideal types.[3] It is almost impossible to discuss social policy without reference to the WRA, yet, as was established in a literature review, it is time to abandon this approach despite (or even because of) what it has offered. Indeed, it might be argued that the more we have learned about regimes, the more we have found them to be deficient. What the approach has demonstrated, to some extent by neglect and omissions as well as by positive contributions, is that social policy theory must accommodate a variety of structural determinants, and how they interact across agencies, processes, relations and institutions to give rise to a diversity of shifting outcomes within and across countries and sectors. This emphasis on diversity as opposed to ideal types generates the potential for further and deeper consideration of theoretical issues and their historically specific and comparative location, for which the theme of financialization and the framework of the PSSOP approach offers an alternative.

The one area where the WRA has been less successful in making a presence is in the context of development. This is a welcome reflection of the distance between social policy, and the prospects for it, in developing countries and those of the developed world. The WRA has also, to some degree, compromised with newly emerging (World Bank) mainstream approaches to social policy. This is based on the idea that social policy needs to respond to market imperfections both in terms of generating the need for social support, broadly conceived, and because of the potential exploitation of it by individuals not in need, or inefficiencies of other sorts due to lack of markets. This has the effect, thereby, of narrowing down both the analytical content of how social policy is conceived (towards

[3] For buzzwords and fuzzwords in development, those that have been used so universally and casually that they border on the meaningless and ideological, see Cornwall and Eade (2010).

emphasis on a narrow understanding based on those individuals at social risk for reasons that remain primarily unexplored other than as due to market and/or institutional imperfections) and the ambition of policies themselves (towards residual relief as opposed to economic and social transformation).

A fourth thread, then, is to acknowledge the overwhelming influence of new mainstream orthodoxies on the understanding of social policy, with an increasing role for the World Bank in the context of development—rubbing out, for example, not only welfare regimes but also the welfare state. The previous couple of decades have not only witnessed the demise of the political economy of welfare approaches (and its substitution by an evolving WRA), but also an increasing erosion of the welfare state as the gold standard and ultimate goal. The developmental welfare state (DWS) (UNRISD 2014) stands out as an exception to this paradigm, although it is far from unproblematic (Fine 2013b). The section on social policy and financialization will reveal the deficiencies of the new orthodoxy, in addition to remedying some of the deficiencies of the developmental state paradigm (DSP) by seeking to marry the DWS and PSSOP approaches.

In particular, the DWS and PSSOP approaches are together fit for purpose, as illustrated in the penultimate section by a critical review of the literature on conditional cash transfers (CCTs), the new kid on the block as far as social policy in developing countries is concerned. The concluding remarks summarize what can be learned for framing social policies.

This Time (Social Policy) Is Different(…iated)[4]

The impact of the current crisis is in some part a consequence of the policies adopted in response to it. Initially, there was some fiscal stimulus, although this rapidly morphed, especially in the USA and the UK, into quantitative easing followed by deflationary measures starting in 2010. According to Ortiz and Cummins (2013), this trend appears to continue at least through 2016 and fiscal contraction is most severe in

[4] See Reinhart and Rogoff (2010).

the developing world. The wide-ranging social implication is particularly notable, as shown in the cases of life expectancy, primary school enrolment and fertility—all of which showed decline by nine months, 3.5 percent and 5.5 percent, respectively (Ortiz and Cummings 2013).

An ideal type of household in this context, established by stereotyped US experience, is one in which: real wages have been held down; provision through social expenditures has been privatized, reduced or even withdrawn; credit has necessarily been used to sustain norms of consumption across commodities and the commodified; and capital gains from housing bubbles have underwritten expansion of credit-fuelled consumption. Also, the coincidental rise of both neoliberalism and finance has exacerbated income inequality, fuelling speculative investment by the wealthiest.[5]

There are, however, questions over this account for a number of reasons. First is to doubt whether the weight of "financialization" of households, let alone its dynamic, is primarily marked and driven by those on low incomes, deprived of social services, realizing gains on the basis of (evaporated) capital gains in housing and unduly dependent on indebtedness through sustaining consumption by credit. This is an empirical question where averages may conceal more than they reveal, not least as the household pressures experienced in the crisis are not necessarily representative of previous experiences. Even across separate elements of the stereotypical household, there are likely to be different impacts from one household to another, rather than all coming together for all in a bundle (Zakrevskaya and Mastracci 2013).

Second, not only are households differentiated by how they are affected by the crisis, and the conditions that preceded it, but so are the extent and forms of financial developments across different countries and sectors of the economy. While, especially for households, mortgage and pension finance may have been to the fore, these have neither been uniformly nor evenly attached to a homogeneous forward march of financial markets.[6]

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[5] Such developments have been understood within a Marxist perspective in terms of financial exploitation of workers, for which see Lapavitsas (2013) for an account and Fine (2010a, 2014a) for an alternative and critique.

[6] Bayliss et al. (2013), Karacimen (2013), Saritas (2013), Churchill (2013), Fine (2013c), Robertson (2013, 2014).

Third, by the same token, both more generally than for mortgages and pensions alone, there has been a difference in how finance has interacted with the separate areas of provision (quite apart from old age and for housing). This is so by sector, by country and by interaction with social policy more generally. Each area of provision will have its own specific dynamics and traditions that will not have been homogenized by its interaction with what is, in any case, the uneven incidence and forms of financial development.

Fourth, it must also be recognized that both finance and neoliberalism are not homogenizing forces (of introducing the market). Even in some sort of pure form, they leave, for example, a residue of those for whom the market is dysfunctional. This gives rise to the hard to house, the hard to provide for in old age, the hard to raise out of poverty, the hard to educate, etc. In short, even the hardest neoliberals are liable to be faced with a Polanyian double (or multidimensional) movement, or reaction against deprivation, albeit of their own making (if also subject to conflict and pressure) and on a greater or smaller residual of the population as opposed to social policy of universal scope.

Further, precisely because such dysfunctions in the hard to serve are multidimensional and uneven in their incidence, individual anomalies are liable to be created across them in the form of either perceived undue benefits (to be cut) or undue harshness (to be alleviated). Unsurprisingly, in the context of crisis and recession, there are pressures both to reduce individual and overall benefits and to protect the most vulnerable. Nonetheless, this does itself create a different sort of double or multi-dimensional movement of policy in squeezing and simplifying what has evolved in the past and yet, thereby, providing fertile ground for piece-meal amendments to protect the most vulnerable as its consequence.

By virtue of the response to the crisis over the past few years, as indicated by Ortiz and Cummins (2013), social policy can go in different directions, not least in response to greater need and vulnerability as opposed to the presumed predilection for (austerity) imperatives especially associated with neoliberalism (just as the Keynesian post-war boom, or periods of growth, might be associated with a remorseless expansion of welfarism). Unsurprisingly, though, at lower levels of disaggregation to individual policies, the incidence of differentiated responses is liable to be even more

variegated, given the specific nature of provision and mixed configuration of determinants beyond macro-level determinants.

In respect of diversity of determinants (and the interaction across them) in assessing the complexity and diversity of social policy, there is a central role played by labour markets, especially highlighted in the context of developing countries. Social policy will, therefore, both served labour markets and also compensate for their shortcomings. Overlaying all of these are gender inequalities, especially around the issues of paid and unpaid work, and corresponding design and implementation of social policy, which may reflect, consolidate or even temper structured discrimination without addressing underlying determinants of disadvantage in economic and social reproduction (Cook and Razavi 2012).

For our purposes, two crucial points follow from this. First, the position of social policy is situated within, and interacts with, broader elements of economic and social reproduction. Second, while Cook and Razavi (2012) focused upon gender, similar considerations apply to inequalities across other social groups, whether by race, age or otherwise. As concluded by Kennett et al. (2013: 261), the diversity of social policy is also generated by other factors such as specific national and local contexts and institutional structures, norms and practices, as well as power relations between and within states, and between men and women.

Social Policy: It's Financialization, Stupid

Social policy might be best viewed as having been underpinned by intellectual plumbing rather than architecture, given the paucity of theory as opposed to framed empirical and statistical analysis around broadly defined explanatory factors (such as globalization, etc.), and structurally determined outcomes. This is especially relevant to welfare regimes, fitted more or less comfortably, if at all, to convergence and path dependence. Such harsh criticism is justified if we consider what is not present within the social policy literature. The most striking absence in light of my own starting point is "financialization", which may be indicative of the weakness in understanding the relationship between it and globalization.

But what exactly is financialization and why is it so important? In brief, financialization has involved: the phenomenal expansion of financial assets relative to real activity (by three times over the last thirty years; Blankenburg and Palma 2009); the proliferation of types of assets, from derivatives through to future markets, with a corresponding explosion of acronyms; the absolute and relative expansion of speculative as opposed to, or at the expense of, real investment; a shift in the balance of productive to financial imperatives within the private sector, whether financial or not; increasing inequality in income arising from the weight of financial rewards; consumer-led booms based on credit; the penetration of finance into ever more areas of economic and social life such as pensions, education, health, and provision of economic and social infrastructure; and the emergence of a neoliberal culture of reliance upon markets and private capital, and corresponding anti-statism despite the extent to which the rewards to private finance have derived, in part, from state finance itself. Financialization is also associated with the continued role of the US dollar as world money despite, at least in the current crisis, its deficits in trade, capital account, fiscal and consumer spending, and minimal rates of interest.

However financialization is characterized, its consequences have been: reductions in overall levels and efficacy of real investment as financial instruments and activities expanded at its expense, even if excessive investment does take place in particular sectors at particular times; prioritizing shareholder value, or financial worth, over other economic and social values; pushing of policies towards conservatism and commercialization in all respects; extending influence of finance more broadly, both directly and indirectly, over economic *and* social policy; placing more aspects of economic and social life at risk of volatility from financial instability and, conversely, placing the economy and social life at risk of crisis from triggers within particular markets (as with the food and energy crises that preceded the financial crisis). Financialization is thus attached to a wide variety of different forms and effects of finance with the USA and the UK to the fore. Even if exposed in acute form by the crisis, its expansion over the last few decades has been at the expense of the real economy, despite otherwise extraordinarily favourable "fundamentals" for capitalist economies, in terms of availabilities of new technologies, expansion in

supplies of labour, weakening of labour and progressive movements more generally, slow increases in economic and social wages under the influence of neoliberal policy, and the end of the Cold War.

Against these perspectives, the significance of financialization is twofold. One is in influencing the conditions of economic and social reproduction of which social policy is both a part and to which it is perceived to respond. Thus, the overall performance of economies, and the levels and composition of (un)employment, wages, working conditions and the inequalities of income and access to consumption that they generate, have been profoundly underpinned by financialization. By the same token, as remarked, financialization has exerted a profound influence on social policy itself given its strong associations with globalization, neoliberalism and their imperatives.

Such postures are, however, extremely blunt in dealing with the diversities of social policy. For them to become more refined, it is germane to pinpoint the relationship between financialization and neoliberalism. It is no accident that financialization and neoliberalism should coincide with one another over the period of the last thirty years. This is certainly true at the ideological level as the imperative of freeing markets has been applied first and foremost to those supposedly pure markets associated with finance. But finance has also been associated with the emergence, strengthening and influence of financial elites at both national and international levels.

As a result, I do not see financialization as a simple associate of neoliberalism but as its defining or underlying aspect, with a reach that goes far beyond financial markets themselves. This is not to reduce neoliberalism to financialization but to see the latter as its central aspect.[7]

Crucial in understanding this relationship is that, despite its scholarship and rhetoric, neoliberalism has always been heavily associated with state intervention. This has, however, primarily been intervention to promote private capital in general and finance in particular, not to compensate for their consequences by virtue of a counter-movement. The response to the current crisis is no exception, in which the crisis within, and not of, neoliberalism has been associated with extraordinary

[7] Fine (2001, 2010b), Fine et al. (2001), Bayliss et al. (2011).

measures of support to finance—both in levels of finance and even in nationalization of failing financial institutions.

This is all indicative of the two phases of neoliberalism, divided by the early 1990s. The first phase is aptly characterized as shock therapy, in which, first in Latin America and subsequently in the former Soviet bloc, the promotion of private capital proceeded without regard to the consequences. The second phase has been in part a reaction to the consequences of the first in terms of the dysfunctions created, not least in social welfare provision. It is also more marked by explicit intervention by the state to sustain the processes of, and underpinning, financialization, as is again starkly demonstrated by responses to the crisis in terms of support to banks as the top priority.

In short, the extent and forms taken by financialization, and the policy responses to it in general, are crucial in setting the conditions to which social policy responds. But, as already indicated, financialization is closely associated with the formulation and implementation of social policy more directly. This is most obvious in terms of the pursuit of privatization in general and of pensions in particular (Bayliss and Fine 2008), as well as in the broader ways in which finance has inserted itself into public forms of economic and social provision. Over the period of neoliberalism as a whole, there has been a shift in the balance of forces operating on the formation of social policy, not only in cuts to (projected) levels of expenditure and in moves towards more commercialized forms of provision, but also together with a neoliberal hollowing out of the policymaking process itself—as governance is subject, for example, to new forms of public sector management and to token and transformed forms of decentralization and participation.[8]

What the social policy literature reveals then, and unsurprisingly, is the multiplicity of factors that go into the making of policy itself, with diversity across and within countries and programmes. However, the nature of this diversity tends to be viewed in terms of location between extremes—dualisms even—with more or less neoliberalism, globalization, stratification, residualism, selectivity, universalism, commercialization, decommodification, path dependence or radical restructuring and so on. Such dualistic approaches are questionable, as these factors should

[8] Almost unimaginably revealed by the formation of unelected and/or powerless governments in the EU!

be seen more as contradictory, or subject to conflicting tendencies, rather than as linear oppositions.

Privatization, for example, takes a multiplicity of forms, from deregulation through subcontracting, user fees and public–private partnerships to denationalization. But a neoliberal push towards private provision can create countervailing pressures for intervention by the state, to subsidize those in need. Similarly, in the case of social security, as with contributory schemes for unemployment, health or (private) pensions, such (quasi-) commercialization inevitably creates a residue that is not covered, which becomes the responsibility of the (neoliberal) state irrespective of the level at which it provides. In this light, residualism, selectivity, etc., are not simply (neoliberal) policy choices but the consequence of (neoliberal) policy, especially in the second phase of neoliberalism in which the dysfunctions and inequities of the first phase have come to the fore.

Care must also be taken, when acknowledging the diversities and specificities of social policy, not to isolate individual elements of welfare provision from one another and from broader functioning, particularly labour markets and gender relations for example. One approach is to locate welfare in relation to economic *and* social reproduction. Consider pensions, for example. On the surface, pensions are simple—the provision of income upon retirement and/or in old age—yet pension systems are extremely complex. First, there are different types of pension systems in terms of levels of benefits and contributions, who pays these, over what period, retirement age itself and so on. Second, there is a corresponding mix across public and private systems. Third, pensions are part and parcel of broader systems of economic and social provision, interacting with other policies such as health and housing provision. Equally, pension provision can be integral to the functioning of both labour and financial markets. Fourth, there are both shorter- and longer-term influences on pension systems ranging over shifting dependency ratios (the contributing relative to the benefitting), the global crisis, and the policies, practices and influences of neoliberalism. Fifth, there are ideational factors attached to pension provision ranging from welfarism to individualism. Sixth, cutting across some of the earlier points, pension systems are perceived to be embedded within national contexts, for example by

reference to welfare regimes, varieties of capitalism or according to the depth and longevity of financial markets.

Indeed, in light of this mix of factors, it is hardly surprising that any survey of pension systems in practice reveals them to be extremely complex and diverse, and classification into ideal types will always be imperfect and subject to change. By virtue of a pension as a source of income, it necessarily conforms to specification of who pays and who receives. To the extent that the latter involves the individual, the pension system can be interpreted as a special sort of financial asset in which saving (contributions) gives rise to benefits (returns). From this perspective, pensions can be treated like other assets subject to more or less favourable treatment by the state in terms of tax advantages and/or subsidies, which can itself be the basis for distinguishing pension systems.

Such a view is at least complicit with the idea of pensions as part and parcel of more or less imperfectly working financial markets, with a lean towards privatizing pensions to the extent that (financial) markets are deemed (to be able) (to be made) to work perfectly. But there is an alternative, in many respects more traditional view, that pensions have little to do with financial markets and are simply part and parcel of social policy and the welfare state or, in grander abstract terms, they are attached to social reproduction. The rich have always accrued assets that may or may not be deployed to provide for their old age, with or without various forms of tax advantages. But this is not necessarily a reason for perceiving pension provision in this way (although it is understandable that a shift in perception would accompany pension privatization and more individualistic and less collective forms of provision).

Further, in departing from the previous view of pensions as a (subsidized or market-imperfection-correcting) asset, the alternative view locates it less in terms of uncertain individual saving/investment decisions over time and more as influence, conflicts even, over levels of collective provision both across levels of contributions and benefits and the forms by which these are determined. Accordingly, different pension systems for the first view are nothing of the sort from the second perspective. Instead, they merely reflect different arrangements for providing (part of) income in retirement/old age as part of, and in interaction with, other aspects of (non-market) provision that otherwise would appear to have

nothing to do with pensions as such (from personal wealth to poverty, housing, etc.).

Such is the position adopted here, but it has methodological implications. Specifically, it involves rejecting the idea that pension systems (as a mix of ideal types or not) are *determined* by their context for an understanding of pension systems as being *defined* by their contexts. In other words, pension systems are to be understood as contingent upon the economic and social system within which they are embedded and not simply to be a product of that embedding.

Consequently, it is hardly surprising that pension systems display commonalities by virtue of what they provide, and yet considerable differentiation within and across countries and over time. This remains the case despite the common pressures experienced by, or imposed upon, pension systems. Thus, the rhythm of pension privatization associated with financialization, the neoliberalization of social policy, and the fiscal and other knock-on effects of the crisis are not homogeneous in themselves nor in their interaction with pension and social provision, quite apart from the different character of national economies within which pension policy is made (if not free of global influences). In other words, as with many other aspects of financialization (and neoliberalism), the implications of financialization for pension provision is necessarily variegated as opposed to mixed ideal-typical. And, in short, a pension system as such cannot be properly understood, let alone explained, independently of its own (national) context, although it remains possible to distinguish between them by virtue of different arrangements of common elements around benefits, contributions, age of retirement, etc. Of crucial importance is how pensions are gendered with correspondingly unavoidable reference to economic and social reproduction as a whole, given different degrees of attachment to, and rewards within, labour markets (see Marin and Zólyomi 2010).

In brief, three grand conclusions can be drawn for social policy: first is to emphasize the diversity of social policy both within and between different programmes; second is that this is fundamentally characteristic and not denial of neoliberalism, as financialized and commercialized forms of provision are not only diverse themselves but also induce equally diverse responses; third, this is only imperfectly captured by a sort

of uneven Polanyian double, more appropriately multidimensional and contradictory, movement across and within different elements of social policy.

Towards Some Alternatives and Against Others

How, then, to frame social policy in light of general determinants, broader context (of global crisis) and diversities of outcomes? To some extent, an answer can be found by drawing the contrast with what has been termed the developmental state paradigm (DSP), and its situating of industrial policy. Significantly, at least until recently, one of the major limitations of the DSP has been its neglect of social policy.[9] The position adopted here is very different in drawing upon and departing from the DSP. First, in many respects, there is no need to treat social policy as different from industrial policy, once recognizing that social policy does itself offer general or horizontal and social provision. Education, housing and health systems are imperative for industrial performance and industrial policy neglects them at its peril. Second, by the same token, social is akin to industrial policy because it is sectoral, using inputs through a chain of provision to provide outputs even if these might be designated as public goods, welfare services or whatever, with income transfers as an obvious exception.

In the past, the developmental state has been to industrial policy as the welfare state is to social policy, each setting a broader transformational frame of reference and ethos, respectively, and with the two lying in parallel with one another. To a large extent, reflecting its own path dependence, the social policy literature continues to hold to this vision, not least with the Scandinavian model, and some form of social compacting and neocorporatism,[10] as the gold standard to be emulated and against which to assess shortfalls of achievement. Increasingly, though, both aspirations and framing have been eroded, marginalizing the attach-

[9] For a critical account of the DSP for this and more generally, see Fine et al. (2013).

[10] Mkandawire (2012), Fine (2016).

ment of consideration of social policy to the transformational goals associated with the welfare state as a key element in development/modernization. To some degree, this is the responsibility of the evolving presence, and predominance, of the WRA. But at least as important has been the increasing appropriation of social policy by orthodox (development) economics, especially in the form of the new welfare economics. This has taken neoliberal antipathy to welfare (and its own commitment to privatization and user charges) as point of departure to see welfare provision as a game, in which the state and individual citizen strategize in relation to one another on the basis of different information and objectives (meeting minimum standards of living at minimum cost for the state, for example, but maximizing income for minimum work by the individual).

This new approach is, unsurprisingly, seriously deficient in at least two major respects. First, in specifying social policy as a response to individual risk and vulnerability, it overlooks the systemic nature of economic and social reproduction, treating social policy as if it were the response to short-term shocks as opposed to a component part of development itself. Second, like the WRA, even if based on universal deductive principles (merit goods, optimization, market imperfections, etc.) as opposed to ideal types, the new welfare economics is insensitive to the contextual differences that mark both countries and policies in terms of individual aspects of welfare provision.

The issue, then, is how to deal with the specificity of particular elements of social policy, in terms of their diversity of causes, content and consequences, without losing grip of the bigger picture. For the latter, pioneered by UNRISD, emphasis has been on locating welfare provision within the framework of the DWS.[11] This has the advantage of foregrounding systemic change in targeting development, welfare and the role of the state. The approach also remains sufficiently open and able to accommodate different aspects and trajectories for development and welfare provision.

Where does this leave the promotion of social policy and alternative forms of (public sector) provision? Initially, we can draw two general lessons. First, there is a need to insulate public provision from

[11] See Mkandawire (2004a, b) and subsequent volumes in the series.

financialization (the direct or indirect effects of turning provision into a financial asset however near or distant). Privatization does incorporate finance directly, with provision potentially becoming subject to the vagaries of stakeholder value on the stock market and other forms of speculative finance. In short, finance needs to be placed in a subordinate not a dominant position. This is easier said than done as, even prior to the crisis, this was said to be true of the role played by the financial system in terms of its efficient mobilization and allocation of funds for investment and its trading in risk. But financialization continues to impinge upon public provision in multifarious ways that can only be guarded against as opposed to being absolutely eliminated, at least for the foreseeable future.

Second, the vulnerability of public sector provision to erosion and distortion is a consequence of the absence of broader supportive institutions and policies in the wake of three decades of neoliberalism. Alternative public sector provision and new, broader policy capacities, and corresponding means and sources of finance must be built in tandem.

Beyond these two generalities, I would emphasize the need to address the specificity of particular types and circumstances of public sector provision in terms of the diversity of causes, content and consequences to which they are subject, but without losing grip of the bigger picture. In particular, my own approach has been to posit the notion of PPSOPs. Specificity is incorporated by understanding each element of public provision as attached to an integral and distinctive system—the health system, the education system and so on. Each PSSOP itself should be addressed by reference to the structures, agencies, relations, processes, power and conflicts that are exercised in material provision itself, taking full account of the whole chain of activity bringing together production, distribution (and access) and use, and the conditions under which these occur.

Thus, the PSSOP approach has the advantage of potentially incorporating each and every relevant element in the process of provision, investigating how they interact with one another, as well as situating them in relation to more general systemic functioning. This allows for an appropriate mix of the general and the specific, signalling where provision is obstructed, why, and how it might be remedied. This is in contrast to unduly focused approaches, those that emphasize mode of finance

alone, for example, as has been the case for housing both before and after its current crisis. At the opposite extreme are unduly universal approaches such as those that appeal to market and/or institutional imperfections, and which accordingly fail to recognize that water provision is very different from housing provision in and of itself as well as in different contexts.

The PSSOP approach has been addressed in Fine (2002, 2005, 2009, 2011a, 2012) for the welfare state and social policy, and in Bayliss and Fine (2008) for electricity and water. I am not so much concerned here to develop, let alone impose, the PSSOP approach more fully as such for, in part, as already argued, it is essential to see it as an approach that needs to be contextually driven rather than as a source of the ideal types or universal theory that characterizes, and even mars, much of the current literature (leave things to the market, or correct market and institutional imperfections, or fit into and enhance a welfare regime). Indeed, the purpose is rather to persuade of the need for something akin to the PSSOP approach irrespective of the controversial methods and theories with which it is deployed, alongside the nature, depth and breadth of economic and social transformation essential for any significant change in provision to be secure. In other words, there is something different about water and housing, for example, just as there is something different about South Africa and India. Further, though, this does allow for the results of existing studies to be incorporated into the PSSOP approach to the extent that they do identify, however partially, the factors involved in provision and how they interact with one another. Of course, in practice, sectorally grounded approaches by electricity, health and water appear to be adopted as if by second nature. But this has not necessarily been so of how they are analytically broached, where sectoral and contextual sensitivity often gives way to universal prescription driven by the neoliberal (or anti-neoliberal) fashion of the moment, whether privatization, user charges, public–private partnerships or renewal of state provision, control or ownership. At the very least, the PSSOP approach offers a framework to address policy needs in light of identifiable provisional deficiencies, broadly interpreted, as opposed to general models and blunt recipes drawing to the fullest extent upon the “market” (that is, private capital and finance), in practice even when recognizing its deficiencies in principle.

In addition, as highlighted in earlier accounts of the approach, not only is each PSSOP uniquely and integrally organized in provision, by country and sector, but each will also be attached to its own meaning and significance for those engaged with (or excluded by) it. For example, whether public provision is seen as household risk management against vulnerability or collective provision towards developmental goals is both cause and consequence of material provision itself and, equally, subject to debate. The cultural system attached to each PSSOP is also integral with material provision and is generated along and around that provision itself. The culture and meaning of public provision, thereby, becomes subject to what has been termed the 10Cs—that the material culture of provision is Constructed, Construed, Commodified, Conforming, Contextual, Contradictory, Closed, Contested, Collective and Chaotic (Fine 2013a). This is important for developing and understanding the meanings attached to public or social provision, not least in prising them away from the negative stance attached to the neoliberal ideology of flawed public provision.

Understanding the meaning of provision is also crucial for finessing the tricky terrain of the role of ideational factors in both provision and policy. This is well illustrated by the discourses surrounding, for example, universal health care. In the case of the United States, it is fairly clear that it is less the idea of universal provision that has to be won, than defeating the alliance of forces, including the private insurance industry and the rifle lobby and their claims of defending freedom (Fine 2011b). Otherwise, appeals to human rights, basic needs, poverty alleviation and equity all have variable and contested meanings, and chances of being adopted and exerting an influence. The PSSOP approach has been extended through the 10Cs to address how ideational and material factors mutually influence one another.[12]

One apparent weakness of the PSSOP approach[13] is its distance, at least initially, from the synergies and interactions across sectors, as with the role of "horizontal" factors (as opposed to the "vertical" provision

[12] For example, with applications separate from provisioning such as financing and the ethics of economics, see Fine (2013c, d).

[13] Another weakness is its focus on welfare service delivery as opposed to income transfers (note, the mirror image of the WRA).

within sectors), such as equity, labour conditions and macroeconomic impacts. Arguably, however, these need to be addressed in their own right *and* in the context of particular sectors within which they are rooted. Indeed, the dialogue between generic and sectoral issues is vital in designing, understanding, promoting and defending public sector alternatives. The virtues of the PSSOP approach can also be acknowledged through the wider evidence on service delivery across the developing world, with wide disparities in success and failure with limited correlation against per capita income (and corresponding implications for such correlations with Human Development Indexes). Thus, levels of literacy and health provision in Kerala (India) and Cuba are exemplary and offer lessons in a comparative exercise for how corresponding PSSOPs might be addressed in other countries by contextually informed emulation (Tharamangalam 2012).

The PSSOP approach, then, is in marked contrast to that taken by the World Bank, whose current stance on social policy incorporates five fundamental characteristics. The first is the continuing influence of its roots within the rhetoric, scholarship and policy perspectives of the Washington Consensus. There is a corresponding lingering presumption of social protection as the response to random shocks that induce individual or household vulnerability that requires at most temporary relief in deference to market solutions.

Second, though, is the flexibility and discretion that is exercised in putative departure from the Washington Consensus. More or less anything can be incorporated on a piecemeal but also, to some extent, an umbrella basis. But this is precisely where the World Bank falls totally short on a more general scale, despite the two other features of departing the Washington Consensus and incorporating more or less anything as social policy.

Third, the social policy becomes developmental without any notion of development, thus able to include anything that is associated with development. This marks a major continuity with the Washington Consensus, for each shares in common a *method* to achieve development without a specification of what development is! For the Washington Consensus, it is reliance upon market forces, whereas its successor depends upon

correcting market and institutional imperfections as well as their accompaniments of poverty, bad governance, inequality and so on, to include anything else for legitimacy or discretion in policy. What is particularly disturbing here is how the World Bank as "knowledge bank" has evolved in such a way that: all economic and social development (and policy) has come under its compass (since all factors and outcomes are mutually conditioning); that the social is increasingly reduced to market imperfection economics; and market imperfection economics in principle, and even more so in practice, is wedded to a tempered neoliberalism across scholarship, rhetoric and policy in practice (see Bayliss et al. 2011; Fine 2014b).

Fourth, then, despite the increased attention to social dimensions of development, the World Bank has adopted a fragmented (in line with its piecemeal) approach. Moser, for example, complains:

> The World Bank does not have a specifically defined social policy as such. Within the institution, three predominant social policy "domains" can be identified: social sectors, social protection, and social development. The fact that each has a distinct location within the organization has served to create artificial conceptual and operational barriers to a holistic social policy. (Moser 2008: 47)

Of these domains, social development is seen as the least advanced. While Moser's jointly edited volume (2008) showcases the role of "assets" as a means of pursuing social policy, her own take on its *absence* from the World Bank might better be seen as *being* the social policy itself to which piecemeal and fragmented correctives are now being appended.

Fifth, the World Bank's own figures tell a contradictory story in terms of the levels of support given to social policy (and for what). Over the eight years from 2000, total expenditure on "Social Protection and Labor Lending" amounted to a little less than USD 10 billion (Holzman 2009). However, in relation to the dollar a day poverty count, this is in the region of a dollar per year for the world's poor. Much more significant is the number of country Risk and Vulnerability Assessments for which funds will have been used in financing consultants, with a total of 127 such Assessments over the period. At about USD 10 million offered per

country per assessment per year (Holzman 2009), the World Bank might be thought to have purchased any corresponding influence over policy at an extremely low price.

This is brought out very clearly in the contributions of Holzman and Kozel (2007a, b) with social policy perceived as social risk management (SRM), with little regard to endemic and systemic poverty—hardly a risk to be managed. Poverty and social policy/protection cannot legitimately be treated as if attached to income and "shocks" alone. As Guenther et al. (2007: 17) puts it, "In policy terms, SRM leads to interventions that focus on transitory income shocks rather than on structural determinants of poverty." Indeed, the presence of the analytical and policy tensions involved in all of this is confirmed by several responses to the current global economic crisis, including Ravallion's suggested response to the financial crisis in "Bailing out the World's Poorest" (Ravallion 2008). This argument often poses that developing countries can and should take responsibility for themselves, except when subject to financial crises other than of their own making (Ravallion 2008). This, however, leads to the question of how social policy relates to a more systemic role not only in "promoting longer-term recovery"—the term deployed in Ravallion's abstract for his working paper, begging the question of recovery to what?—but also in bringing about economic and social transformation.

Are Conditional Cash Transfers the Answer or Do They Not Even Pose the Right Questions?

There are, then, considerable and shifting tensions in the World Bank's positions on social policy across ideology, scholarship and policy. These can be highlighted by addressing the one major innovation that has marked policy over the recent past and continues to sustain considerable momentum: conditional cash transfers (CCTs). CCTs have rapidly shot to prominence over the past decade, particularly in Latin America but also elsewhere, including Bangladesh, Cambodia, Kenya and Pakistan (World Bank 2009).

For the World Bank, CCTs serve in some respects as an ideal instrument in response to the second phase of neoliberalism in crisis. Yet, as then Chief Economist Justin Lin put it:

> Even the best-designed CCT program cannot meet all the needs of a social protection system. It is, after all, only one branch of a larger tree that includes workfare, employment, and social pension programs … As the world navigates a period of deepening crisis, it has become vital to design and implement social protection systems that help vulnerable households weather shocks, while maximizing the efforts of developing countries to invest in children. CCTs are not the only programs appropriate for this purpose, but as the report argues, they surely can be a compelling part of the solution. (World Bank 2009: 12–13)

Accordingly, the level and design of the programmes in practice are discretionary; the boxes of addressing the poor, children, health and education are ticked; there is potential for institutional and other externalities into broader social provision; ambition in potential is matched by modesty of aspiration; and, analytically, there is scope for spillovers and general equilibrium effects, empirical investigation of short-run as opposed to long-run impact, and for theory drawing upon market and institutional imperfections to be corrected on a piecemeal basis.

Most telling, though, is the detachment of CCTs from broader economic and social provision other than as the context in which they may or may not succeed. In any case, conditioning income support on accessing health and/or education is contingent upon these services being available. As noted by the World Bank:

> Clearly, a supply of health and education services of adequate quality must be developed … Cash transfers may be the right policy instrument to alleviate poverty in the short run, but their contribution to longer-term poverty reduction also will depend on what happens on the supply side. (World Bank 2009: 202)

But it is a moot point whether such progressions and conditions are best delivered through CCTs, given that they have been situated in a neoliberal context in which individualization and commodification are the

order of the day in the absence of a pre-existing welfare state providing corresponding services.

Indeed, it would appear precisely because CCTs have proven themselves to be potentially consistent with, rather than antagonistic to, private (possibly state-supported) provision of social and economic infrastructure that the World Bank's initial scepticism has turned into a relatively warm embrace in order to use the state to support the private sector in such provision where privatization has proven impossible or unsuccessful (Fine and Hall 2012).

In this respect, like all social policy, outcomes necessarily both reflect *and* contest entrenched structures, relations, processes, powers and agencies.[14] At a specific level, let alone more generally, the idea that there will be universal solutions on how to balance (or more exactly transform and promote, respectively) one against the other borders on the ridiculous in both analytical and strategic terms. Further, in terms of the political content of CCTs, they act as both a site of conflict and a means to temper it, with the opportunity to gain electoral support relatively cheaply in terms of cost and extent of reform. In short, while there are those that express support for CCTs as a major success with continuing potential subject to careful, contextual implementation, Fajth and Vinay (2010) perceive CCTs as only welcome if providing momentum towards universalism in social policy: its ultimate success depends on a simultaneous expansion and improvement of universal services in health and education (Mattei and Sanchez-Ancochea 2011). Universalism is set against the conditional, targeted ethos of CCTs, and viewed as more effective and secure in practical and political terms.

Here, there is a stunning silence across the World Bank literature, and much more besides. It is as if the *welfare state* as the embodiment of universalism and public provision does not and has never existed. Of course, much the same is true of the absence of the (radical) political economy of welfare literature that approached the status of orthodoxy a generation or so ago, focusing on the design and function of welfare

[14] For critical approaches to CCTs on these terms see Lavinas (2013), and for the particularly successful *Programa Bolsa Família* in Brazil see Saad-Filho (2015).

for advanced capitalism.[15] These absences are hardly surprising for the Washington Consensus, not least with its neoliberal and Americanized inspirations. But why should it be so for the post Washington Consensus, with its rediscovery of its own version of Keynesianism, market imperfections, public and merit goods and so on? By contrast, the modernization aspirations of what might be termed the "pre-Washington Consensus" were heavily influenced by the notion of emulating the welfare states of Western Europe. For this, in contemporary developing country circumstances, we need a marriage of the PSSOP approach with that of the DWS. And, again in acknowledgement of, if moving beyond the DSP, such an approach is liable both to promote the interests of, and strengthen the presence of, those who have most to gain by its developmental content as opposed to consolidating neoliberal forms of governance that have so signally failed for developing countries over the past decades.

Conclusions as Starting Points

The global crisis, together with an international climate that is at least nominally committed to human rights, basic needs, poverty alleviation, improvements in human development indices and well-being, etc., has put the issue of social policy on the agenda as never before—not only in the differentiated and differentially impacted and served developed world, but also across the equally diverse developing economies. In this light, how are social policies to be understood, explained and made?

A number of lessons can be drawn from the extensive literature survey that has been undertaken, leading to conclusions that might even be thought to be nothing more than a new common sense. Nonetheless, deeply embedded conventional wisdoms remain entrenched, despite what is their relatively recent vintage in the historical sweep of welfare provision and the salient lessons that might have been drawn from the crisis that such conventional wisdoms had deemed preventable, if not no longer possible. Such postures derive primarily from the imperatives

[15] Note that Ravallion's (2008) own contribution only references at most a few pieces from outside the immediate orbit of the World Bank.

and experience of neoliberalism just as their Keynesian/modernization/welfarist predecessor exercises at most a lingering, nostalgic nudge to those who seek alternatives.

First, then, is to acknowledge the diversity of social policies across time, place, context, programme, causes, content and meaning, and influence of conditioning factors and variables. The idea that, for example, the South African health system can be understood in the same frame as the UK water system is simply nonsensical even allowing for variations in typologies, models or whatever.

Second, this implies that grand, especially inflexible, approaches to the understanding of social policy are not so much doomed to failure nor to offer no insight, as to do so only on the basis of more or less useful, and casual, empirical specifications of social policies and the determinants and outcomes associated with them. This is especially true of the WRA that dominates the literature, but equally of other typologies and schemes for assessing the nature and dynamics of social policies such as whether there is convergence, divergence and/or path dependence in their evolution.

Third, this is not to throw hands up in horror, eschew general theory and historical narrative (to specify the nature of contemporary conditions) and to conclude that everything is so complicated and contextually determined that we can only expect to realize a heterogeneous sack of case studies across countries and policies. On the contrary, it is essential both to address the nature and significance of underlying and general influences. These include the nature and influence of neoliberalism and globalization and, as emphasized here and in departure as yet from the existing literature, the role of financialization in determining social policies both directly and indirectly. Further, as demonstrated here, these grand variables are not at all forces for homogenizing social policies but are fundamental in bringing about their heterogeneity.

Fourth, insofar as there have been shifts in social policy thinking over the neoliberal period, it has been towards reducing how it is understood and what it constitutes. Drawing upon mainstream economics and notions of the state as simply a mediator in the market, and institutional imperfections faced by individuals, and especially in the hands of the World (knowledge) Bank, whose scope of policy making increasingly accepts no bounds, social policy has been understood as temporary, residual relief.

What is notable in such an approach, apart from its predilection for the market forms of provision and the scope it allows for discretionary intervention, is the absence of an explanation for the need for social policy in the first place (other than to alleviate the results of "shocks"), dependence upon universal principles that are not attuned to country- and policy-specific contexts and the absence of the role that social policies play in the processes of development.

Fifth, then, and more constructively, a particular approach to framing social policy has been put forward that, at least in principle, addresses these identified deficiencies. This is to treat each social policy as an integral system in its own right, tracing provision from beginning to end as in a health system, education system, housing system, pension system and so on. This has been dubbed the PSSOP approach. Further, while the initial focus is upon the functioning of such systems in providing core outcomes, it is equally recognized that they are embedded in a broader economic and social dynamic that also needs to be specified, with implications (as for all policies and for which the comparison with industrial policy, for example, is salient) for employment, gender relations, equity and so on.

Last, as already indicated, it is inappropriate to locate the progressive making of social policy purely in terms of a residual safety net or whatever as opposed to its reflection of, and contribution to, economic and social change or development. For this reason, it is proposed that the PSSOP approach be integrated with the notion of a developmental welfare state. While the DWS, like social policies themselves, is liable to be heterogeneous in its presence, content and meaning, by incorporating it into policy making there is some guarantee that broader issues will be forced into consideration in terms of both causal factors and targeted outcomes (just as the welfare state served as an analytical and policy template in the Keynesian era).

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3

Universalism and Health: The Battle of Ideas

Susanne MacGregor

Introduction

The Rise of Universal Health Care as an Affordable Dream

Universal health care is often presented as an idealistic goal, out of reach to all but the richest nations. Amartya Sen, however, thinks this is not the case, pointing to what has been achieved in Rwanda, Thailand and Bangladesh. He argues that "basic healthcare for all can be provided at a remarkably good level at very low cost" (Sen 2015). Many countries now aspire to universal coverage—like China, Mexico and Brazil—though with varied success.

Universal health care is primarily a normative concept. In practice, there are varieties of health care systems shaped by their historical and

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contemporary contexts, and there are winners and losers in all systems, depending on the balance of power. The outlier is the United States—showing yet again that country's exceptionalism, although President Obama's achievement in extending access to health care against much opposition should not be overlooked.

There is now a momentum towards universal health care, with 12 December 2014 being declared Universal Health Coverage Day. On that day, 535 organizations came together to support the goal, with 30 events being held in 100 countries. This marked two years since the 2012 (12-12-12) UN Assembly Resolution on universal health care. Supporters include the World Health Organization (WHO), the World Bank, the Rockefeller Foundation, Action for Global Health, Save the Children, GlaxoSmithKline, the *Lancet* and many others. The aim is to build resilient and responsive health systems, involving diagnostic capacity, effective information systems, technology, speedy early response, good data, enough facilities and staff and supplies of medicines. Universal health care is seen as a powerful social equalizer.

Contested Concepts

The two foundational concepts that are most greatly contested in this area are "universalism" and "selectivism". Contentions diverge primarily between ideas of a welfare (or health and well-being) state and neoliberalism. The idea of social investment is currently promoted as a compromise between these two poles.

The Idea of a Universal Right to Health

There is now a growing commitment at the global level to universal health care and recognition of it as a human right. Access to quality health care is seen as a matter of social justice, linked to participation and democracy: health policy decisions are placed "squarely into the domain of law" (Yamin 2005: 1157). When access to health care is construed as a matter of right, it becomes one of state responsibility and obligation. As Yamin (2005: 1158) notes, "human rights as enshrined in international

law offer a powerful alternative discourse to the prevailing market oriented one". It is also a way of holding states to account and measuring their performance. A key development from this approach has been the incorporation of a right to health within the constitutions of a number of countries, presented as a new social contract between the state and the citizen. For example, in 1988, Brazil made social security a right of citizenship saying that this was "at the very core of efforts to promote a successful democratic transition" (ISSA 2013: 21). The basic principles of this constitution included universality of coverage and service, equivalence between rural and urban areas and equal participation in funding.

The first notion of a right to health under international law is found in the 1948 *Universal Declaration of Human Rights*. In 1978, at a meeting in Alma Ata in the then Kazakh Soviet Socialist Republic, the world's health ministers endorsed the goal of *health for all by the year 2000*. Then in 1995, at the Copenhagen World Summit on Social Development, eight major goals were declared, including achievement of universal and equitable access to education and health. In 2010, the case for universal health care was advanced in the World Health Report on health systems financing. In an introduction to the report, the Director General of WHO stated that there is abundant evidence that "raising funds through required pre-payment is the most efficient and equitable base for increasing population coverage" (WHO 2010: 6). In December 2012, the UN General Assembly—through the unanimous adoption of a resolution on global health and foreign policy—encouraged governments to plan or pursue the transition towards universal access to affordable and quality health care services (UN General Assembly 2012). The 2013 Lancet Commission on investing in health argued for "progressive universalism"— publicly financed health insurance schemes where the rich pay more than the poor (Lancet 2013). The vision for stronger and more equitable health systems has now been embedded in the Sustainable Development Goals with target 3.8—"Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (UN 2015)."

As well as the overriding aim to provide financial protection in the event of ill health, especially avoiding catastrophic health care costs, there are three aspects to universal health care: access to quality health services,

including by the young, old and disabled not in the labour force; interventions to promote a healthy society and individual well-being; and sickness benefits to cover absence from the labour force due to acute or chronic conditions. The core principle is that people should contribute according to their ability to pay and receive health care in response to need. The underlying financing system needs to be equitable with minimal reliance on payment at the point of use. Financing should be via pooling, rather than segmented according to disease or population categories. In reality, most low- and middle-income countries are far from having such a health system, and most systems are regressive. Out-of-pocket payments and regressive tax systems are the main culprits with most people having to pay at the point of use.

There are four key organizing concepts in the evaluation of health systems: effectiveness, efficiency, humanity and equity (Smith et al. 2005: 14). Effectiveness describes the benefits of health services measured by improvements in the health of a real population. Efficiency (or cost-effectiveness) relates the cost of an intervention to the benefits obtained in terms of health gained. Humanity describes the social, psychological and ethical acceptability of the treatment that people receive. Finally, equity refers to the fair distribution of health services among groups or individuals. The WHO evaluates health systems performance by the level and distribution of health, financial protection, responsiveness and efficiency of resource use (WHO 2000). Mandatory contributory systems have proved to be the most efficient. In order to build effective financial systems, governments need to reduce tax evasion and expand the tax base. Favoured steps towards universal health care involve an incremental strategy, gradually extending across three coordinates: proportion of the population covered, proportion of direct costs covered and range of services provided (WHO 2010: 20). Critical conditions include a fair taxation system and efficient use of resources.

Arguments for and Against Universalism in Health Care

Competing arguments for and against universal health care reflect broad oppositions: between public and private, between the state and the market, and between universalism and selectivism. The selectivist argument

rests on the idea that individuals can and should establish their own right to health care. The universalist case is that society has an obligation to look after the health care of its people. Systems are *universal* in distinction to those which are *corporatist*—applying only to those employed and financed through contribution; and as distinct from *liberal or residual*, i.e. those that target the poor.

Sen and Drèze (2013) have succinctly articulated the case for universalism in health care:

> A health system based on targeted insurance subsidies is very unlikely to meet basic norms of equity in healthcare as four different sources of inequality reinforce each other: exclusion errors associated with the targeting process; screening of potential clients by insurance companies; the obstacles (powerlessness, low education, social discrimination, among others) poor people face in using the health insurance system; and the persistence of a large unsubsidized component in the health system, where access to health care is linked with the ability to pay insurance premiums. (Sen and Drèze 2013: 155)

The concept of universalism is not straightforward—there are various interpretations. Universalism may best be considered as an ideal, a vision and a goal, serving as a rallying call and aid to mobilization. It may also be seen as a measure by which to evaluate different systems. The case for universalism rests partly on evidence and partly on moral argument, referring to values of equality, equity and efficiency. "Universalism is an abstract ideal used to denote that all citizens are treated with equal concern and respect" (Vabø and Szebehely 2012: 122). Universalism is not simply the opposite of selectivity. There can be positive selectivity, where the needs of certain categories, groups and territories are met (Anderson and Ytrehus 2012) and negative selectivity, which is principally means-testing (Vabø and Szebehely 2012: 122). A "sophisticated universalism is sensitive to diversity" (Vabø and Szebehely 2012: 123). Universalist services can be preventive if used by all the population and delivered through socially approved channels.

Titmuss had earlier warned against oversimplifying the distinction between universal and selective (or targeted) services (Abel-Smith and Titmuss 1987). These have many forms, he observed, and selective

services can play a role within a universalistic system. Marshall (1965) distinguished between universal programmes that guarantee a social minimum and those that strive to provide a social optimum. Targeting, by contrast, is when the scope of beneficiaries is more restrictive. More recently, Mkandawire (2005) noted that policy regimes are hardly ever purely universal or purely based on targeting—most are hybrids.

The desire for universal services has often grown from an awareness of the problems surrounding services targeted at the poor. Experience has shown that use of these is stigmatizing and can involve a loss of dignity and self-respect. Thus, a key question in the debate has been about whether services should be organized for the poor only or whether they should include, in particular, the middle class. One common criticism of public services that include the middle class is that they benefit the middle class unequally (Le Grand 1982). This criticism is only valid, however, if the goal of social or health policy is merely the reduction of poverty. If, however, the aim is *security* (reassurance or removal of fear), then a more broadly based provision is not a waste of resources. A key bone of contention in debates is thus about the ultimate purpose of policy—with one side arguing for the centrality of *poverty reduction* and the other arguing for the centrality of *security and social integration*. In this latter conception, affordable and accessible health care is a core characteristic of a civilized society (Tawney 1964; Marshall 1965). Protection from hardship due to ill health aims not simply at the prevention of destitution but at maintenance of a normal or accustomed standard of living. This is also a goal attractive to middle-income groups and thus encourages their participation in that pooling of financial resources required to fund such systems: it also has the effect of building a strong political coalition to defend services. So long as the risk of illness is seen to be generally shared by all citizens and not specific to particular occupational or lifestyle groups, then such support can be maintained.

Health systems have developed historically through voluntary insurance contributions by skilled workers or the middle class as they recognized their shared risks. Development into universal health care schemes involved the state taking a role by insisting on compulsory savings and, through its involvement, being able to cover poorer groups or irregularly or non-employed groups by subsidy from taxation. Varieties of schemes (roughly Bismarckian or Beveridgean) have been related to the type of

benefits (flat-rate or earnings-related), how far variations between occupational groups were maintained, the forms of administration of schemes (trade union, employers and/or state, local or national government) within which formerly excluded groups were included, and length of coverage—short or long term. The wider the pooling of risks and resources, the more universal the scheme.

Where provision of health care through the market is the dominant form, health care may be overpriced and provision distorted, encouraging overdiagnosis, overmedication and long hospital stays as in the USA. Private insurance schemes typically exclude people with chronic conditions or high-risk groups. Involvement of the middle classes in schemes adds their political power and influence to coalitions supporting the maintenance and enhancement of good-quality universal health care. A state-organized health system aiming at the well-being of the whole population should be in a better position to pay more attention to preventive health care (Phelan et al. 2010). Reliance on consumer choice, as advocated by neoliberals, is inappropriate in health care, as individuals require the expert advice of professionals in making decisions about medical treatment. In any case, it is argued that doctors and nurses should be guided by ethics, not the pursuit of profit. Health as a public good therefore needs state involvement.

Other arguments for universal health care are that everyone benefits from a more healthy society (Sen 2015: 32; Wilkinson and Pickett 2011). Advocates argue that the institutionalization of universal health care has wider effects on social harmony and encourages trust in the state and support for state involvement. The feedback loop in universalism involves a process whereby public provision and the acceptance of state responsibility create a constituency of the taxpaying public. This constituency is encouraged to share experiences through use of shared services, thereby leading to a sense of social solidarity and institutions that are more resilient. The result is a more equal society and better overall social well-being and social cohesion. Public provision is accompanied by the growth of a public service ethic, improved state capacity and trust in government. These observations are supported by evidence of less inequality and greater trust in the state in countries with universal health care systems.[1]

[1] Clarke (2004), Marmot and Wilkinson (2005), Mooney (2012), Navarro (2008), Sandel (2012).

For universalists, shared provision is thus a good in itself, supporting a set of values which privilege ideas of the public, common humanity and social justice. These ideas may also link to traditional, religious concepts, for example of the duty to provide hospitality and assistance to the stranger, or the principle of altruism (Titmuss 1970). However, the idea of altruism and the belief that there is such a thing as a public service, professional ethic (one that supplies a better motive to providers of such things as health care than the maximization of profits) were criticized by Le Grand (1997). He argued that few of those working in the public sector are entirely public spirited, but nor are they simply self-interested egoists. He also raised the issue of the need for citizens to play an active role as consumers of public services (Le Grand 2006). He proposed, therefore, replacing professional ethics with quasi-markets, establishing market relationships between providers and their customers.[2]

Critics of universalism see the involvement of the state in health care provision as leading inevitably to bureaucracy, an ossified and inflexible system characterized by provider capture (Wilson 1975). A key argument against public provision is that this will also involve rising public expenditure and inflationary pressures. Opponents of universalism claim that where there is state health care, vested interests such as public sector workers and public sector unions become entrenched and unwilling to negotiate, often leading to disregard for the broader public good. High public sector pay crowds out private sector enterprise and investment, and accompanying problems include corruption and complacency. Such critiques argue that it is valuable to involve the private sector. Private firms can be outsourced and can specialize in delivery. The adoption of business criteria, they argue, increases efficiency.[3]

More recently, the argument for attention to health *systems* and the promotion of universal health care, especially in low- and middle-income countries, has arisen not so much from the above range of general arguments but as an alternative to the many disease-specific programmes that have proliferated and developed in an ad hoc way in response to various crises and epidemics. There are, for example, specific programmes for vaccination, tuberculosis (TB), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), malaria, polio and for specific groups

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[2] Le Grand and Bartlett (1993), Le Grand (1997), Le Grand (2006).

[3] For example, see Osborne and Gaebler (1992), Seldon (2007).

such as children and pregnant mothers. In the 1990s, health systems also moved towards the delivery of selective primary health care. Critics point out that the lack of attention to the whole person in such targeted schemes means they are often ineffective. Much targeting assumes that it is possible to identify specific needs and simple outcomes. A complex array of separate, targeted programmes has appeared, often provided by different contractors with different donor funding regimes, different categories and rules, and different time scales. The result is overly complex and inefficient.[4]

The key point is that human beings, especially those in need of social protection, have complex needs and their situations can vary over time. To deal with this complexity and variability, an integrated systems approach is best. In addition, universal schemes for social protection should be integrated into and link with other areas of social policy in a comprehensive system, acting in a mutually supportive and reinforcing manner.

Further support for collective and universal systems rests on the argument that certain public goods are best provided at the highest level of government, with tax collection being optimal at the highest (national) level. In these systems, all are in the same risk pool, generally the nation-state. The pooling of risks is a key principle: systems will be more efficient and have lower costs, the more are included in the scheme. All benefit from a larger risk pool. The universal system is simpler and less complicated and administrative costs are lower.

A different form of criticism of universalism came from the left and from feminists based on recognition of issues of diversity (Anttonen et al. 2012). Feminists point out that where responsibility for caring is attributed to women, this tends to maintain a particular family form involving male dominance. Where women are formally employed, this is often in caring roles within state services such as in the health service—a limited inclusion and equality. However, others argue that health systems are part of the public sphere, thus encouraging women's political participation, and, although segregated within these systems, equal rights and equal opportunities are established (O'Connor 2004). The development of universal services can be seen as a form of civic republicanism and thus a strong challenge to neoliberalism. Empirically, however, the inclusion or exclusion of women from politics varies by country. Underlying

[4] WHO (2000), Gröne and Garcia-Barbero (2001), McLaren and Hawe (2005).

these limitations are issues of the sexual division of labour with women continuing to take on the bulk of caring work, paid or unpaid. In many health systems, with their focus on treatment and hospital-based delivery, social care is underfunded and undervalued. It is not an accident that women play the major role in social care.

Such critiques, based on awareness of diversity and difference, refer also to the dark side of the Enlightenment, citing examples of eugenic policies in mid-twentieth-century Germany and Sweden and the treatment of deviants or "others" like alcoholics, drug takers, the mentally ill and people with disabilities. Further criticisms cite evidence in the actual development of Western universalist health systems of the dominance of bio-medicine, the privileging of hospital care versus primary care, the strength of the pharmaceutical industry and its vested interests, and the patronizing approach of so-called experts, especially instituting male dominance and patriarchy in the organization of health care (Light 1993; Goldenberg 2006). Other criticisms are of the way Western systems suck in workers from the developing world, recruiting health workers trained abroad to fill vacancies, leaving the countries of origin under-resourced (Khassoum 2004; Stilwell et al. 2004). They cite the exclusion of women, the low-paid and irregular workers from access to sickness benefits (Sainsbury 1993; Schoen et al. 2010). Thus the concept of universalism is empty if it simply means male universalism and it is a hollow vision of solidarity that excludes migrants. A damning charge against universalism is that of hypocrisy. Diversity is thus a challenge to universalism (Clarke and Newman 2012). Pressures for individualization, more choice, consumerism and personalization undermine many of the principles on which universal health institutions have been founded.

Andersen (2012: 164) argues that there are seven criteria of universalism: (i) the right to benefits or services; (ii) that they are tax-financed; (iii) that they are uniform throughout a country; (iv) that they are enforced through compulsory legislation; (v) that they are designed for the entire population; (vi) that the entire population has equal access; and (vii) that the majority of the population are users. Using these measures, few countries could claim to have attained complete universalism in their health or social provision. While in the past decade there have been louder voices arguing for universalism, from the late 1980s (mainly due to the collapse of the Soviet Union and the apparent triumph of capitalism) there were

strong pressures working against it. Around the turn of the century, a compromise between these two tendencies appeared in ideas of social investment, which tried to pay attention to the 'social' while playing down the role of the 'state'.

Ideas of Social Investment

The idea behind this compromise was to invest not so much in states as in individuals, families and communities. Feminist thought had had some influence, and more attention was given to social care and gender roles. These ideas arose to counteract extreme neoliberalism, but involved accepting essential concepts and assumptions of liberal economics and many of the criticisms of state provision (Fine 2001). These policy ideas were seen as realistic and politically feasible. It was argued that health expenditure can contribute to economic growth. Investing in human and social capital became a key theme. Sen (2015: 33), for example, argues that there is a strong relationship between health and economic performance and that a healthy population is necessary for economic and social development as well as being a good thing in itself. Investment in health, as well as in education, advocates claim, raises the productivity of labour.

Interestingly, and importantly, ideas of universal health care fit happily in this paradigm. The UN General Assembly resolution of 12 December 2012 recognized that improving social protection towards universal coverage "is an investment in people that empowers them to adjust to changes in the economy and the labour market and helps support a transition to a more sustainable, inclusive and equitable economy" (UNGA 2012: 5). Rising support for universal health care reflects the broad alliance—a centrist consensus—behind social investment ideas. The focus is on populations, workforce capacity and infrastructure development in which health provision plays a key role. Rather than expenditure being seen as a burden or a cost, health policy can be a positive factor in economic development. East Asian productivist systems such as Singapore seemed to exemplify this with their commitment to education, health and social services (Gough 2000). Critics of the social investment perspective objected to its productivist assumptions with everyone, including children, being seen solely as workers or potential workers

(Lister 2003). Within the social investment perspective, attention to adult women focuses primarily on maternity and particularly their contribution to demographic growth (Jenson 2010). There is no attention to feminist demands such as for equal pay. Investing in children is central, rather than women's rights and redressing the unequal contribution to caring. Jenson concludes that the social investment perspective converges around a package of ideas about modernization, social inclusion and social investment (Jenson 2010: 471). Gender equality, however, is not one of its aims (Jenson 2009).

In this policy frame, new forms of service delivery are said to be required, with a need for modernization to address new issues. However, these ideas emerged in a period of boom. Following the 2008 financial crisis, in many countries there has been a return to strict retrenchment: as Standing (2011: 79) argues, "the demonstrated willingness of governments to cut public spending and public sector debt has almost become a litmus test of credibility for international portfolio managers".

Mobilizing Ideas and Capturing Power

Change in the way issues are framed can occur with the experience of crisis, such as war or economic depression or following environmental crises such as epidemics. Such crises open "windows of opportunity" for the new ideas to enter into the political arena (Kingdon 2013). Examples regarding health policy include changes following the Second World War under reconstruction, as part of nation-building agendas, following independence from colonial powers, or with democratic transition after the experience of dictatorship. Change may alternatively come more gradually within an existing political regime, as a result of pressure from below exercised on elites who make concessions in order to retain power. These concessions aim at political stability and the maintenance of social order.

As noted by Midgley (2004: 255), "in the industrial nations enhanced state intervention was closely associated with post war reconstruction … in the developing nations, government engagement was closely linked to the struggle for independence from European imperialism". In both sets of circumstances, the drive for improved social provision was linked to ideas of progress, social justice and planning. A key aspect of the legitimacy of

the modern state is its ability to meet health care expectations. In binding populations into the state, often through the negotiation of a new "social contract," the extension of access to health care has played a key role.

In explaining the move to universal health care in high-income countries (HICs), attention has been given to interest-group formation, along with the role of affluence, demographic change and the political power of older people in electoral democracies (Wilensky and Lebeaux 1958). Titmuss (Abel-Smith and Titmuss 1987) saw the forces leading to the welfare state as being mainly the fear of social revolution, the need for a law-abiding labour force, the social conscience of the rich and the role of political parties and pressure groups competing for power. However, he thought the most important force was the working class ethic of solidarity and mutual aid.

Korpi (1989) argued that the extension of social citizenship through modern social policies was a fundamental macro-level social change in the twentieth century. In particular, he drew attention to the role of leftist government participation in the extension of social rights. For example, the development of the more universal and comprehensive Swedish welfare state can be attributed to the prolonged dominance of its social democratic party in government. Being in government is clearly important in effecting change, as with the post-war Labour government in the UK, and even in the case of the Obama administration in the USA. Similarly, it has been the capture of power by popular parties in Latin America that has built on the mobilization of progressive forces to implement moves towards universalism in health care once in control of the levers of power.

Commonalities and Differences in the Experiences of High- and Middle-Income Countries: The Influence of Context and Conditions

Much of the experience of universal health care derives from the history of HICs. However, it has been argued that there are severe limits to the application of Western-based explanations to the rest of the world. Theories and explanations emerging from studies in the North cannot be automatically applied to emerging economies (Gough 2000). Socioeconomic factors that influence the potential for universal health coverage include levels of marketization, industrialization and income.

Different forms of peasantry, land ownership, kin structures, household forms and gendered relationships also need to be taken into account.

Some criticisms relate to the feasibility of advocating for universal health care in a different political context. Gough (2000) argues that the emerging economies, when compared to Northern welfare states, have a different distribution of power resources. There tends to be weaker class organization of politics and more particularistic, regional, patrimonial and clientelistic forms, resulting in the adverse incorporation of weaker groups. State institutions may involve a less embedded, or absent, set of democratic practices. Social policies cover a greater range of functional alternatives to Western-style social protection beyond the state, for example religious, enterprise-based, non-governmental, foreign aid, local/communal, clan and household provision (Gough 2000).

Thus, what is or has been appropriate and successful in Europe may not be so elsewhere. Sen (2015), however, supports the idea of learning from the experiences of others. He comments on the strange resistance to this in some quarters with consequent problems of reinventing the wheel or repeating mistakes. Midgley (2004: 217–18) has also pointed to shared interests and concerns across countries, identifying the "emergent realities of a global one world system," and "the activities of international development agencies which have exerted considerable influence on social policy thinking in non-western societies".

Technical assistance from the 1960s onwards encouraged a sharing of ideas between North and South and across countries. As noted by Midgley (2004: 227), "the United Nations played a key leadership role in promoting the adoption of social development… The community development approach was also infused into health care and became a primary mechanism for promoting health and nutritional improvements in many countries" in partnership with national planning agencies.

The 1970s saw problems of debt and the impact of structural adjustment programmes and the rise of neoliberal ideology: this led to the demise of ideas of planning and the parallel rise of aid officials, consultants and international development experts. An increased role was given to non-profit organizations and community groups partly to circumvent what were seen as inefficient or corrupt state agencies. The focus of attention was on health, children and women, especially poor women.

In the late twentieth century, approaches based in neoliberal ideology put pressure on many countries at different income levels to reduce

public expenditure, retrench social spending, impose more demanding eligibility requirements on recipients and develop activation policies. These ideas were purveyed by social policy advisors employed by the International Monetary Fund (IMF) and World Bank. Some of these argued for reductions in public expenditure, the privatization of health services and limiting public investment to services that were calculated to be "cost-effective". One set of ideas focused on the benefits of "managed competition" (Schieber 1997).

The agenda was to divert public money into private businesses, privatizing profits while socializing losses, meanwhile denigrating state intervention and ignoring cultural traditions, especially those found in familial and solidaristic communities. Their aim was to promote a radical individualism. In measuring and benchmarking the performance of health systems, they tended to ignore the role of non-state agencies in promoting health, especially the unpaid work of women. Patients became "consumers" of health care—but were unable to consume where services disappeared or where they were "failed consumers" (Baumann 1998), because they were too poor to afford them. The aim was the commodification of health care and the shrinking of social sector spending.

But now, universal health care is presented as a global health goal and global responsibility. A number of countries have led the way. In Brazil, a series of initiatives between 1990 and 2006 encouraged moves towards universal coverage in health. An important and famous development was the *Programa Bolsa Família*, a conditional cash transfer programme to very poor families with children, which aimed to alleviate poverty and encourage regular health care visits. A monthly permanent income for the disabled was instituted. The 2011 programme *Brasil Sem Miseria* targeted 16 million poor people and improved access to health care. A key driver was support from political leaders: social security reform has required the investment of tremendous political capital (ISSA 2013: 35).

Thailand's moves towards universal health care date from the 1997 financial crisis. Debates on the rights and obligations of "social citizenship" characterize policy options. Technical expertise, especially from health economists, has played an important role. Out-of-pocket health spending is now less than 15 percent of total health spending (viewed as a critical cut-off point for universal health care) (Mongkhonvanit and Hanvoravongchai 2014).

In communist welfare states, public provision of health care had been part of a wide package of rights. All this disintegrated with the end of the Soviet Union. The collapse of the Soviet Union was catastrophic, leading to the rapid erosion of public institutions and the worsening of social inequalities (McKee 2002). Policy now aims to improve health, following a critical period in which life expectancy, particularly for men, fell dramatically (Shkolnikov et al. 1998). For instance, in 2011, the law "Concerning Compulsory Medical Insurance in the Russian Federation" outlined a single compulsory health insurance framework for all Russian regions (ISSA 2013).

India has also introduced state-driven mass health insurance schemes in recent years (ISSA 2013). In China, dramatic improvements have been made. Health insurance has expanded coverage from 24 percent of the population in 2005 to 94 percent in 2010. In 2006, the government committed to health insurance aiming to cover the whole population by 2020 (ISSA 2013: 14). South Africa also launched an ambitious universal health care scheme in 2012 (ISSA 2013).

Thus, while the expansion of health and social security used to take place mainly in developed countries, the past two decades have seen major moves towards universal health care in emerging economies, especially in Brazil, Russia, India, China and South Africa (BRICS). A brief overview of experiences of developing social and health provision in both HICs and in BRICS indicates the important role played by different class coalitions and by inherited institutions in the specific ways adopted in pursuit of the goal of universal health care (Gough 2000). Different regime profiles result in different health outcomes (Mossialos et al. 2015). A crucial concept is that of de-commodification, that is the extent to which health provision is taken out of the market—not seen as a commodity but as a public good.

These examples illustrate the role of *power* in the shape and direction of policies. With regards to health policy, a key issue is the relation of doctors to the state. The influence of the medical industry and insurance companies is generally an important one (Buxton 2014; Surender 2014). The more state intervention is accepted, the less independent power doctors have. However, the medical profession, with pharmaceutical companies and other aspects of the health industry, continues to play a leading role in defining health needs.

While there is growing support for universal health care, considerable opposition is also evident, for example in the USA, where arguments

against universal health care were furiously voiced throughout the debates surrounding the Obama administration's attempts to achieve health care reform. These included the view that this involves an unwelcome intrusion by the government into private choices. The opposition to Obama's reforms came from a general distrust of the state and directly from the medical establishment and right-wing ideologues. Socialized medicine has long been a focus of anxiety and tension throughout the country.

Overview of Drivers of Change

From the above illustrations, it is clear that the drivers of change reflect social values, political institutions and traditions, different legal systems and health care communities. There are differences between the principles of design and the practices of implementation. Across countries, values differ regarding respect for individual or collective interests and the role of the family in caring. Cultures may be individualistic, egalitarian or communitarian.

A key feature is state efficacy, that is, the ability to get things done. A unitary centralized state may be most effective, although this can also lead to a tendency to intervene too much and too often. Where a polity involves sets of countervailing powers, as instituted in the US Constitution, this can be a barrier to reform.

An overriding conclusion is that "*politics matters*". It does so through the mobilization of resources—in the form of social movements and through social protest. These protests become effective when links are made to channels of power and political institutions and finally the acquisition of dominant power enabling the introduction of legislative reforms.

Developing Effective and Appropriate Institutions: Working with Health Systems Variations

When the vision of universal health care is to be put into practice, governments have to look at the existing institutional framework and decide whether it is possible to reshape these institutions or whether it is necessary to invent new institutions to deliver these aims (Mills 2014). In

many countries, some form of health insurance and access to health care will have become available to certain groups, often to government servants, civil servants and the military, for example, and employees in private companies. In some, programmes targeted to the poor or towards specific categories such as pregnant women or pre-school children or towards specific diseases such as TB or HIV/AIDS may be present, often relying on global funds. However, at this stage, the bulk of the population may be reliant on out-of-pocket payments, which leads to financial catastrophe when severe illness or accidents strike.

Few systems are fully comprehensive: in Canada, home health care and drugs lie outside the public system; in France, dental and eye care tends to be covered by supplemental insurance. With advances in medical innovation, there is everywhere more pressure to decide what baskets of benefits are the responsibility of the national government and which the responsibility of the individual. How funds are raised also varies. In the UK this is mainly via general revenues; in Canada both national and provincial general revenues are involved; in Germany funds are raised primarily through work based social insurance contributions; in France there is a social insurance regime supported by general revenues. France and Germany also involve some forms of cost sharing by patients. Different systems involve different mixes of public/private provision and responsibility, different degrees of market or central planning, and different forms of financing, organization and management of local or national responsibilities. The key to these differences lies in the degree of government involvement in the funding or provision of health care (Blank and Burau 2004).

Systems may be broadly categorized as private, social insurance or tax-financed. The USA represents the most liberal form—with health care being financed by employers and or employees, through mostly private provision but some state provision, especially for older people, the poor and veterans. In general, the country has been said to have the best medical system and one of the worst health systems. Sen and Drèze comment that the US health system is "one of the most costly and ineffective in the industrialised world: per capita health expenditure is more than twice as high as in Europe but health outcomes are poorer (with for instance the US ranking 50th in the world in terms of life expectancy)" (Sen and Drèze 2015: 156).

The social insurance or Bismarckian model rests on compulsory health insurance—a combination of employer, employee and state provision

with some private provision resting on fee for services. Insurance is publicly mandated but involves independent institutions. The tax-financed or Beveridgean model involves largely state administration and state ownership. Interest in the sustainability of health systems reflects concerns around pressures from ageing societies, medical advances and public expectations. Proposals for demand side policies aiming at cost containment include user charges and co-payments and, on the supply side, generic prescribing, caps on budgets, use of waiting lists, and more controls on doctors' practice through inspections, league tables, guidelines and use of targets. But co-payments have been shown to create inequities, raise barriers to access and usually do not achieve their goals (Rasell 1995; Evans et al. 1993).

Crucial components of a more universalistic system are the presence of an effective and legitimate state, an efficient and meritocratic civil service, ideas of professionalism and professional ethics, and ideas of human rights and citizenship. Implementation depends on expertise and planning capacities, a strong state and a trusted state willing to intervene and regulate the market. Other enabling factors include low levels of corruption, the public's willingness to pay taxes and the state's ability to collect them.

State Capacity

State involvement in health care can operate on any of three dimensions: *regulator*— that is involving laws and sanctions; *distributive*—since health care is a public good; and *redistributive*—where there is a deliberate attempt to shift resources to poorer groups and those previously excluded from provision. In universal health care, the major forms of redistribution are from the healthy to the sick and from the young to the old. In making all these decisions, conflicts are ever present—in a sense, all politics is a battle over the distribution of resources and the field of health is one of the most important and most emotionally charged.

Once a financing system has been put in place, the state has a key role in regulating it. Where systems have developed incrementally, there can be a confusion of segmented and/or parallel subsystems leading to inequities, fragmentation and, in some cases, "medical apartheid". The task for the state is to coordinate and integrate these over time, aiming at

wider risk-pooling where possible and implementation of common standards. All these tasks require a high degree of organizational capacity and technical competence within state bureaucracies. Parallel systems tend to segment the population into three groups: the poor (unemployed and employed) without social security, the salaried working population with social security; and the rich with private insurance.

The necessary capabilities for efficient systems include information collection, computing capacity, data analysis, risk assessments, and the reliability and integrity of systems. Trust in government is essential for the functioning of all systems, but especially so for the universalist: government—politicians and state employees—have to be seen as competent and as representing the national interest. This could be promoted through education and training, open meritocratic entry and transparency of appointments and payments.

Tax systems are fundamental to instituting universal health care: the social state is a tax state. Sen and Drèze (2013) argue that building a strong publicly financed health system is critical even if there are other non-public insurers and donors in the mix. If a state cannot organize effective and reliable systems, then devolving administration to commercial or not-for-profit insurance companies is an option. Even here, however, the state has a key role to play as only the state is able to back up decisions through the application of the law and, ultimately, by force. Thus, revenue raising and fair taxation are fundamental to social schemes: as well as arguing for a fair balance between direct and indirect taxation (direct are more progressive but indirect less visible and less subject to avoidance and evasion), a variety of ways to extract more taxes have been discussed—from the tried-and-tested corporation taxes and inheritance taxes, plus land value taxes and "sin" taxes, to more recent ideas like taxes on global financial transactions and other revenue raising devices like city bonds or social impact bonds. In the global economy, a key question is how to tax the offshore rich, international oligarchs and transnational corporations that seem able to successfully avoid national taxation.

To protect health systems from rising demands, the social determinants of health need to be tackled as well. The growth in the influence of multinational corporations on lifestyles (Freudenberg 2014) undermines the general health of society, increasing the burden placed on health

systems. Health status is highly correlated with the social and economic determinants of health (Marmot and Wilkinson 2005). Unhealthy behaviours such as smoking, alcohol and drug abuse, violence, sedentary lifestyles, obesity and poor diet, among others, are disproportionately present in lower socioeconomic groups (Blank and Burau 2004: 201). Attacking poverty and inequality and reducing unemployment and precarity as well as improving education and infrastructure would have major impacts on overall population health. Indeed, reforms to promote universal access, to improve quality of care and to contain costs may improve the medical care system in general, but they cannot be expected to substantially improve the health of the population (Blank and Burau 2004: 207), as these efforts fail to pay sufficient attention to what does improve health—escaping from poverty and securing access to nutritious food, clean water, sanitation, shelter, education and preventive care (Barnett and Whiteside 2002).

New Challenges

There are, in addition, a number of new pressures impacting on attempts to implement change. Changes in the labour force, especially involving increases in women working and an associated increase in precarious, insecure, part-time employment, pose challenges (Standing 2011). Globalization has involved increased migration, challenging notions of citizenship as the basis for social rights. With urbanization and internal migration come changes in family structures and tests to caring responsibilities. Demographic changes are occurring with the increased size of populations, and in many countries, an ageing of the population is leading to a reduction in the ratio of working to dependent people, while other countries are characterized by large numbers of younger people. All societies see increased polarization, inequality, poverty and marginalization, alongside vast increases in wealth.

There are pressures towards increased individualization. The contemporary, relatively fragmented, heterogeneous systems of organizing political interests are environments less favourable to expansive universal social rights (Pierson 2001). Cultural distinctions remain. These challenge notions of universalism and collectivism. At the same time, however, basic

human vulnerabilities to sickness, accidents, old age, death, childbearing and childrearing remain and are common to all societies. Universalist systems assume a fundamental existence of universal human needs, a common humanity (Doyal and Gough 1991).

Bio-medical and technical advances continually place upward pressures on health expenditure. There are pressures to make health a business opportunity. The model of public purchase and private provision remains influential. In this period of dominant financial capitalism, a global private market in social provision has been created with the possibility of private health care and hospital providers, social care agencies and social insurance companies mainly in the USA and Europe benefiting from an international middle-class market (Deacon 2000). This process has been actively encouraged through the promotion of international trade agreements.

Conclusion

Universal health care has not been fully achieved anywhere and is under constant threat. There is a need to struggle for its advance and to defend its institutions once built. Currently in Greece, for example, one-third of the population are now without national health insurance. Many sick people are dependent on "solidarity" health centres which use donated drugs and medical equipment and depend on voluntary labour from professionals (Sen 2015). The key question is whether governments act as the courtiers or the challengers of international capitalism. Are national governments able and willing to stand up to global financial oligarchies? This is not an easy task, as their opponents are enormously powerful and ruthless. Progressive forces include international alliances of health professionals, international organizations like the WHO and international non-governmental organizations, trade unions and social democratic and socialist parties, and social movements, especially those mobilizing women, ethnic minorities and indigenous people. In many countries, civil society has played a prominent part in securing citizens' rights and the right to health. These reforms were motivated by social justice and equity and the desire for democracy and citizens' rights, especially

in those countries in which there had been military dictatorships and human rights abuses (Atun et al. 2015). However these achievements remain fragile and inequities remain.

Some see universal health care as a moral imperative (Etienne 2015). While learning from others' experience, each country must define its own path, taking into consideration its unique historical and contemporary context. The practical way forward is to build on what exists as far as possible but where there are significant distortions, it may be necessary to circumvent these and build new sets of institutions.

A complex of interrelated forces need to be present to progress moves to universal health care. "Political stability, committed leadership, sustained economic growth, and strong health systems are crucial for achieving universal health coverage which is hindered by income inequalities" (Atun et al. 2015: 15). The authors of *Good Health at Low Cost* (Balabanova et al. 2011) see access to primary health care as the crucial requirement. Good health policies are more likely to emerge in supportive social policy and political contexts: this involves legislation, stakeholder partnerships, improved gender relations, bureaucratic effectiveness, an improved sense of solidarity and recognition of the role of civil society (Balabanova et al. 2011). The general ideological framework also matters: Farmer (2015) has commented that "it is difficult (perhaps almost impossible) to achieve equity of access to decent healthcare when neoliberal market paradigms underpin care delivery."

Universal health care is an idea whose time has come. It is a rational response to the pressures of industrialization and urbanization and the need for social integration. It is propelled forward by upward pressures from democratic politics, protests and social movements and top-down by the need for political stability and social order. The interests of nation building and popular desires for social protection add to support for better health care.

The key element in universal health care is that it provides *security* from fear, insurance against the threat of adversity following accident or illness. It is a concept that can serve as a rallying call for reform. It is necessary to continue to make the case for universal health care as opponents are ever present, saying that selective systems are more efficient and effective and that countries cannot afford universal health care. There are strong opposing forces within financial capitalism to any moves towards

more progressive social and health policies and many of these operate at a remote level and are deliberately concealed. The argument of this chapter has been that, ultimately, decisions are made by groups of people acting together politically to promote their vision. Politics matters—and can offer the promise and opportunity for change, building on analyses and experience with organization and willpower.

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Part II

Moving Towards Universal Health Care: Opportunities and Challenges

4

The Politics of Health Care Reform in Thailand

Erik Martinez Kuhonta

Introduction

When seeking to explain policy success, one major debate in the policy sciences literature has centred on the method of reform: a big bang approach versus a gradual or incremental approach. The advantages of a big bang approach include increased credibility of reform (Lipton and Sachs 1990), rapid disbursal of benefits (World Bank 1991) and higher barriers for the opposition to coalesce against the reforms (Krueger 1993). A gradual approach, on the other hand, has the following benefits: it may prevent excessive costs, especially at the beginning of a reform process (Dewatripont and Roland 1992; Nielsen 1993), it allows trial and error and mid-course adjustment (World Bank 1991) and it helps a government to gain gradual credibility (Fang 1992).

While useful in framing policy reform in the big picture, an emphasis solely on immediate versus gradual reform is limited because it does not address some fundamental political questions that matter for explaining policy success. These questions lie at the heart of the comparative

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politics literature. Does the state have the institutional capacity to actually implement reforms? Is there political will behind reforms that will inevitably incite opposition?[1]

In this chapter, I will argue that the creation of a major policy reform initiative in the developing world—the universal health care programme in Thailand—can be best explained by combining the literature on policy reform that emphasizes the *approach* to reform and the comparative politics literature that focuses on institutional *capacity*. Thailand's universal health care programme was forged through a big bang approach. With a new government elected in January 2001, the programme was operational in six provinces by April 2001, and just 12 months later was functioning all throughout Thailand. The speed with which a reform programme with far-reaching implications was implemented is itself remarkable.

The broad macro factors that created the conditions for successful rapid implementation included the introduction of the 1997 Constitution and the Asian financial crisis. The new constitution created a number of institutional and electoral changes that had the effect of strengthening political parties. This, in turn, helped propel programmatic policies, such as the universal health care programme. Crucially, the new constitution created conditions for government stability and, therefore, for policy sustainability. A further effect of the constitution was to empower civil society forces that were also vital for the passage of the universal health care programme. The Asian financial crisis played a key role in underlining the need for social equity and helped to bolster the political power and popularity of the Thai Rak Thai (TRT) Party, a populist reform-oriented party led by Thaksin Shinawatra, which campaigned on a pro-poor agenda in the lead-up to the January 2001 elections and then went on to implement the universal health care programme. In this regard, political parties were crucial to Thailand's big bang approach. Without political power committed to reform, the universal health care programme would not have been at the top of the political agenda and would not have passed so quickly through the legislative process.

However, it would be a mistake to simply pin the programme's success on the big bang approach and the political events of 1997. While the implementation of the universal health care programme was rapid and

[1] Evans et al. (1985), Kohli (2004), Kuhonta (2011).

immediate, its origins can be traced to sustained efforts, beginning in the mid-1970s, by committed reformist bureaucrats to develop such an initiative. The reservoir of bureaucratic commitment and capacity was crucial to the government's push for policy reform. It was the reformist bureaucrats who provided the evidence-based knowledge, past practical experience and institutional networks necessary for the forging of the universal health care programme. Without the foundation laid over several decades by the progressive bureaucrats, the universal health care programme would not have had the institutional capacity for making it through the myriad obstacles that come in the way of such a major reform initiative.[2]

"First, due to their career paths in the Ministry of Public Health, they [progressive bureaucrats] had acquired a deep knowledge and experience of the Thai health care system", writes Illan Nam:

> Their years working as physician practitioners in the public health system, in both urban and rural regions of the country, gave them an intimate knowledge of the salient challenges to health equity … Over the course of their long careers, they acquired an unusual combination of practical and theoretical health care expertise. Second, these physician-bureaucrats were informed by their progressive beliefs in the inviolability of equal and universal health care for all citizens. Due to their experiences of working in rural regions, they were especially attuned to the plight of villagers and dedicated to improving their well-being. Lastly, they were proactive in cultivating associational networks. (Nam 2015: 171)

Thus, both approach and capacity were crucial to the initiation and implementation of Thailand's universal health care programme. The big bang approach was effective and possible because of institutional and economic changes that enabled a populist, reformist party to come to power, and that also strengthened the rights of civil society. Nevertheless, it was the presence of reformist bureaucrats that provided the capacity

[2] Joseph Harris (2015) has termed the progressive bureaucrats' role as a form of "developmental capture" in order to emphasize the unique action that these civil servants have played in pursuing the public interest. "Developmental" is usefully contrasted to "regulatory capture", in which interest groups use a state agency for narrow, particularistic purposes.

for such reform in terms of skills and the knowledge of past efforts that enabled the policy's implementation.

Known as the 30 Baht "Cure All Diseases"[3] Programme, wherein most medical interventions are covered with a minimal 30 Baht (approximately USD 0.80) co-payment, this reform initiative has led to universal coverage of health care for virtually all Thai citizens. It has also significantly increased per capita spending for the poor, prevented a catastrophic impact on the incomes of the poor, reduced infant mortality rates and legitimized a pro-poor discourse in electoral politics—something that had been altogether lacking in Thailand's previous experience of democracy. One central prong of the programme—reallocating medical resources to the rural sector—was eventually weakened by a counterreaction from conservative bureaucrats and urban doctors, thereby limiting the full reformist thrust of the 30 Baht Programme. The political will of the government and the capacity of the reformist forces have not been able to fully overcome all challenges to the 30 Baht Programme. Yet, in its broadest contours and crucial aim of universal coverage, this programme has delivered huge benefits to the poor, and it is now institutionalized as a fundamental component of the policy landscape, and considered a basic right of all Thai citizens. Despite consistent criticism from mainstream economists and media outlets that the programme was simply an electoral gimmick that would wreck the economy and lower the quality of health care, the programme has proved sustainable. Notably, the military government, which took power after ousting Thaksin and his TRT Party in 2006, maintained the programme and even eliminated the 30 Baht co-payment.

This chapter will begin by addressing the inequalities in the Thai health system. It will then move on to discuss the origins of health care reform, while a third section will focus on the political context for the emergence of the 30 Baht Programme. The fourth section then addresses the implementation of the 30 Baht Programme, as well as the challenges it faces. A final section concludes by discussing some of the recent political dynamics surrounding the 30 Baht Programme.

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[3] "*Raksa tuk rok*."

Inequalities in the Health System

Thailand is one of the most inequitable countries in Southeast Asia. As measured by its Gini coefficient, Thailand ranks as the most unequal country in the region. During the height of the economic boom in 1992, Thailand's Gini coefficient registered a high of 0.536. For the past 15 years, it has hovered above or around the 0.50 mark (see Fig. 4.1).[4]

Traditionally, the health care system has been one major element in Thailand's inequitable structure. A number of glaring inequalities have characterized the health care system. These include: (i) the allocation of spending; (ii) the access to health services; and (iii) regional disparities. In terms of spending allocation, the health system has largely favoured middle-class bureaucrats. Prior to the establishment of the universal health care programme, the health system was divided into four schemes:

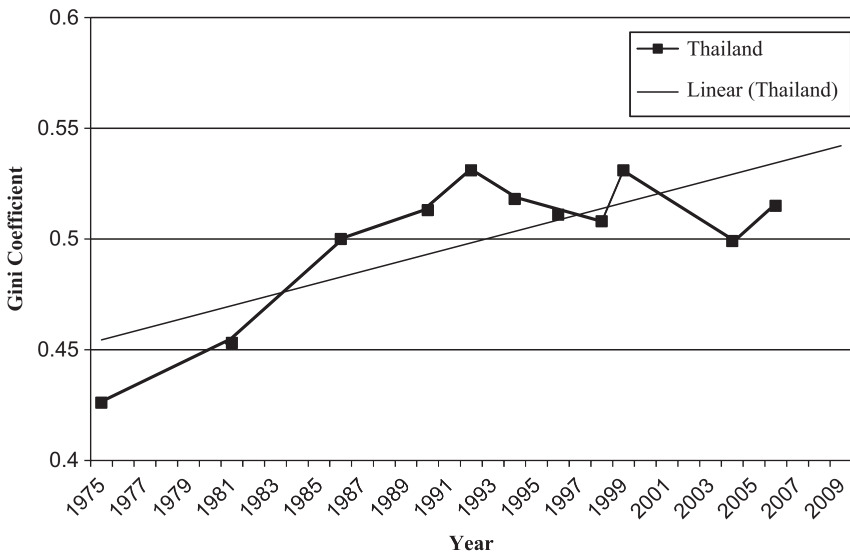

Fig. 4.1 Trend in income inequality in Thailand, 1975–2006 (*Source*: Revised from Kuhonta 2011: 7)

[4] For a comparative discussion of inequality in Southeast Asia with case studies of Malaysia, Thailand, Vietnam and the Philippines, see Kuhonta (2011).

the Civil Servant Medical Benefit Scheme (CSMBS), the Social Security Scheme (SSS), the low-income scheme (also known as the Medical Welfare Fund) and the 500-Baht Health Card scheme, which was also for those with a lower income. The per capita allocations heavily favoured the CSMBS. In the mid-1990s, its per capita allocation was Bt1780, while that of the SSS was Bt711, and that of the low-income scheme was Bt225. The discrepancy index—the ratio between expenditure per capita of each scheme and the low-income scheme—was eight for the CSMBS and three for the SSS (Supachutikul 1996, as cited in Nitayarumphong and Pannarunothai 2005: 266).

Until the universal coverage scheme was inaugurated in 2001, about 28 percent of the population remained uninsured. Hospitalization rates were lowest among the uninsured relative to the insured within any scheme (Pitayarangsarit 2004: 10). A provincial health survey showed that 28 percent of the poorest households who should have been covered by the low-income scheme were uninsured (Ministry of Public Health 1997, cited in Pitayarangsarit 2004: 11). Those who were uncovered by any health scheme also had half the hospitalization rates of those covered by health schemes and their out-of-pocket costs represented a higher percentage of their income than those with higher incomes (Pannarunothai and Mills 1997). Households with low levels of education, occupation or income were less likely to be able to cover health care costs when their family members fell ill. Individuals were also reported to be denied treatment if they lacked insurance coverage, while delayed treatment led to health complications and physical disabilities (Siamwalla 2001).

Given the high discrepancy in terms of spending for the different schemes, it follows that access to health services has also been skewed in favour of the bureaucratic class. The health benefit scheme correlated with health status and the probability of an individual's hospitalization (Pannarunothai and Mills 1997). Therefore, those in the low-income scheme had lower health status and were less likely to visit a hospital when ill. The problem with the low-income scheme and the health card scheme is that they were also perceived as lower-quality programmes. They therefore reduced the likelihood that poor people would seek medical help.

Finally, there has historically been a huge disparity between the resources allocated to the rural sector and those given to the urban sector. In terms of hospital beds, Bangkok has had four times as many beds as the northeast, the poorest region in Thailand. Furthermore, the ratio of doctors to population was much lower in Bangkok and the central region because of doctors' preference for working in urban, tertiary hospitals, where the salaries are higher. The skewed ratio of doctors that favours the urban sector has been the Achilles' heel of Thailand's health system. In the absence of a better balance between the number of doctors in the urban and rural sectors, health inequalities have been difficult to fully redress because funding has tended to be channeled disproportionately towards the centre, largely to maintain higher salaries.

Origins of Health Reform

The origins of health policy reform can be traced to the period of student activism in the mid-1970s. In October 1973, university students succeeded in overthrowing the military regime of Thanom Kittikachorn and Praphat Charusathien and thereafter continued the drumbeat for social and political change in the three short-lived years of democracy. The push for political change, however, had been initiated prior to the democratic years from 1973 to 1976.[5]

In 1969, Puey Ungpakhorn, director of the Bank of Thailand and rector of Thammasat University, founded the Thailand Reconstruction Movement and the following year he established the Thammasat Graduate Volunteer Centre. These programmes were aimed at sending university students to do volunteer work in the provinces. Similar to the United States Peace Corps, these were the first programmes to expose urban middle-class students to the conditions of dire poverty in the countryside. Within the same spirit, the government also mandated that graduates of medical schools were to serve for several years in rural hospitals. Through

[5] For a good analysis of this period and its relationship to the eventual forging of the universal health care programme, see Nam (2015), Chap. 3.

this programme, a group of doctors began to live and understand the urgency of reform in the health care system.

This led in 1978 to the formation of the Rural Doctors Society by a group of doctors from the elite medical universities in Thailand. The aim of the society was to support doctors working in the countryside. It then became the institutional base for progressive reforms in the Thai health care sector. These doctors were involved not just in medical work in rural hospitals, but also in activities such as social development work, community insurance schemes and the like. In the mid-1980s, leading figures in the Rural Doctors Society began scaling the ranks of the Ministry of Public Health. Besides their positions in the Ministry of Public Health, members from the Rural Doctors Society also joined civil society non-governmental organizations (NGOs) and political parties, as well as the private sector (Bamber 1997; Wibulpolprasert and Thaiprayoon 2008: 360).

In 1986, the reformist doctors established the Sampran ("Rose Garden") Forum, which served as an "alternative and autonomous" informal think-tank from which ideas about health reform could be discussed and developed from within the otherwise conservative Ministry of Public Health (Nam 2015). From the Sampran Forum, other organizations and associations were formed to further the networks and ideas of the progressive physician-bureaucrats. These included the Health Systems Research Institute, the Thai Health Promotion Foundation, the National Health Foundation, the International Health Policy Programme, the National Health Security Office (NHSO), the Society and Health Institute and the National Health Assembly (Harris 2015: 173). By the early 2000s, members of the Sampran Forum had gained top positions in the Ministry of Public Health. Two members of the Forum served as Deputy Permanent Minister, while several others were executives in various departments in the ministry (Harris 2015: 174).

An early pilot effort that sought to test the viability of universal health care in Thailand was known as the Ayuddhaya Project run by Dr Sanguan Nitayarumphong—a member of the Rural Doctors Society—and several Thai and Belgian doctors. Beginning with a northeastern district in Si Sa Ket, the project expanded to the provincial level in the central province of Ayuddhaya in 1989, and then spread to six other provinces in 1995. The project had three key characteristics. The first was the creation

of a flat-rate payment-per-visit fee structure to ensure that any medical intervention would be affordable to patients. The rate was set at Bt70 (approximately USD 2.50), through discussion with the local community. Second, local health centres were to serve as the first stop for primary care and were to be closely linked with larger hospitals. By focusing on primary care as a first stop, the goal was to find a way of managing costs as well as the flow of patients in provincial hospitals. Third, the ties between the community and the health provider were to be a central aspect of the system. In particular, the community would be involved in assessing and, when necessary, raising the co-payment. The emphasis on the community was intended to encourage patients to be more involved in their health conditions, as well as to provide information on patients' behaviour as a means of improving health provision. The most distinct aspect of this project was the financing scheme that set a flat-rate payment. This would later be the prime characteristic of the universal health care programme under Thaksin Shinawatra, although the fee would be lowered to Bt30 (Turner et al. 2012).

In the mid-1990s, under the leadership of Sanguan, reform-minded bureaucrats with seats on the parliamentary health commission joined with a number of Members of Parliment (MPs) to draft a bill for universal health care, but this bill languished in parliament and lost support following a reshuffle in the upper echelons of the Ministry of Public Health (Pitayarangsarit 2004: 21). The push for this bill had developed out of the government's success in 1990 in enacting Thailand's first Social Security Act that provided for health care coverage for employees in the private sector. The Social Security Act was a milestone piece of legislation that had come to fruition out of a coalition of reformist bureaucrats, MPs and trade unions. Crucially, it had passed in the lower house of parliament by a unanimous vote despite the threats made by the army commander-in-chief and senator, Suchinda Kraprayoon, that passage of the bill would lead to dire consequences.[6] Unlike the movement for social security, however, the proponents of the universal health care bill had not developed a broad coalition to advance their proposed legislation. Nevertheless, this experience would aid them in rethinking political strategy in favour of a

[6] Indeed, Suchinda would later lead a successful coup against the government in 1991.

broader coalition linking civil society activists, progressive bureaucrats and political party reformists.

Political Context for the 30 Baht Programme

Two macro-structural factors, arising in 1997, were crucial in creating the enabling conditions for the advent of the universal health care programme. These were the passage of the 1997 "People's" Constitution and the Asian financial crisis. The new constitution was crucial in two ways. First, it provided a number of institutional and electoral changes that had the overall effect of strengthening political parties. The greater coherence of parties meant that there was more emphasis on programmatic policies. Furthermore, the new constitution specifically bolstered TRT's position by granting it greater stability and longevity of governance. Second, the constitution significantly expanded the rights of civil society. This, therefore, helped progressive forces to further the agenda of universal health care. The Asian financial crisis, in turn, was critical in highlighting the problems of poverty and inequality, when Thai governments had long emphasized economic growth. In this context, the crisis created the opportune moment for a party with the foresight of TRT to position itself as a reformist force for change. With the financial crisis as backdrop, the popularity of a party with a populist and reformist plank was solidified. In essence, the new constitution and the financial crisis created the "perfect storm" for the advent of universal health care.

At the same time, it bears emphasizing that while the events of 1997 created the right conditions for change, this change was possible in large part because reformist civil servants in the Ministry of Public Health, along with their own independent progressive associations, had long been working incrementally towards universal health care reform. Thus, a policy foundation for pursuing universal health care was already institutionally available—although not yet implementable in political terms.

The 1997 constitution was crucial in strengthening the position of TRT and allowing the party to govern unimpeded by intra-coalition factional politics—the cause of many governments' rapid collapse in the

1980s and 1990s. In the big picture, the new constitution helped reduce the number of political parties and significantly increased the power of the prime minister relative to coalition partners and intra-party factions (Hicken 2006; Kuhonta 2008). These reforms provided the means for Thaksin and TRT to dominate the political machinery. With political dominance assured, Thaksin's policy agenda, driven by populist as well as programmatic social reform, had the political and legislative muscle necessary for effective passage and implementation.

Central to the constitutional changes was a new electoral system that has had profound consequences for national advocacy and party support for universal health care. The creation of a party list pushed parties to campaign on programmatic policies with national resonance, while the advent of single-member districts also strengthened the linkage between politician and party, while reducing intra-party competition at the district level. The cumulative effect of both the party list and single-member districts has been to strengthen majoritarianism at the national level, which, in turn, furthers parliament's capacity to push through programmatic policies. As the electoral changes took effect, the electorate also began to expect that parties would advocate programmes that emphasize the public interest and this, in turn, reinforced for parties the importance of national programmes. The new electoral system therefore created incentives for the formation of national parties with programmatic agendas that in turn helped to make the 30 Baht Health Care Programme part of TRT's electoral platform (Selway 2011).

In addition to strengthening political parties, the 1997 constitution also gave greater political space to forces in civil society. Following the failure to pass the bill for universal health care in parliament in the 1990s, Sanguan acknowledged that he and his reformist colleagues had not considered strategy enough in terms of creating a broad coalition to back up their vision. Thus, the next move to push for universal health care was the formation of a coalition made up of civil society groups, reformist bureaucrats, academics and politicians—what Nam has termed a "solidarity coalition" (Nitayarumphong 2006: 71–3; Nam 2015). This movement, dating from June 2000, sought to educate groups in civil society, particularly the urban poor, farmers and women's groups about

the importance of universal coverage.[7] Teaming up with Sanguan, Jon Ungpakhorn, a senator, prominent non-governmental organization leader and son of Puey, headed a network of over 100 NGOs in driving an extensive campaign for the passage of the bill.

Using the provisions of the 1997 constitution that allowed for a bill to be sponsored and debated in parliament by attaining 50,000 signatures, a universal health care bill penned and shaped by civil society made its way into the halls of parliament. This so-called "People's Bill" advanced the idea of free universal care for all citizens, called for the merging of all existing government coverage schemes, proposed a "no-fault" liability for patients that mandated that any patient injured during a medical treatment would be compensated without having to prove fault, and pushed for significant institutional changes in the way in which national health care is structured. On this last point, the bill sought to separate purchaser and provider functions in the health care system, both of which the Ministry of Public Health had controlled. The intention was to create autonomy for the purchasers so that they would be able to effectively represent the interests of patients. But a second crucial aspect of this proposed institutional reform was intended to replace the supply-based funding model with one based on a capitation system that would, in effect, rebalance funding in terms of population size and therefore would increase funding to the poorer regions of Thailand. Furthermore, in an effort to redirect resources from urban to rural hospitals, the bill sought to have hospitals cover the budget for their own staff. The overall effect of such profound institutional changes that were strongly supported by the Rural Doctors Society would be to weaken the Ministry of Public Health's control over the health supply system, budgetary authority and general mandate—turning it into a regulatory as opposed to an operating agency (Nam 2015: 194). Replacing the ministry's control on many issues related to universal health care would be a new organization, the National Health Security Office.

[7] Interview, Jon Ungpakhorn, Bangkok (24 June 2009). One significant move by NGOs was sending "trainers" throughout the countryside to educate villagers about the benefits of universal health care. "Using the language of citizens' rights to health care which the 1997 Constitution had guaranteed, the civil society representatives conveyed the universal coverage's central promise: that all Thais—whether poor, rich, urban or rural—would be guaranteed an equal package of health benefits and services that they would receive without having to demonstrate eligibility" (Nam 2015: 192).

With some 70,000 signatures attained, parliament was required to address the bill, debate it and vote on it. Civil society had therefore forced the hand of parliament in taking on a bill that promoted universal health care. However, parliament delayed the counting and verification of signatures, so that the government bill on universal health care—that was then also going through the pipeline and that was modeled heavily on that of civil society—went through parliament first.[8] Nonetheless, this was only the second time that a bill drafted by civil society had been considered in parliament. Most importantly, the "People's Bill" served as the template for the National Security Health Act that eventually passed.

Besides a new constitution, the Asian financial crisis that began in July 1997 also opened up space for TRT's reformist agenda. The crisis not only had significant macro-level financial effects, it also triggered a reversal in some of the socioeconomic gains made in the boom years preceding the crisis. Many businesses collapsed, and in turn, many middle-class Thais fell below the poverty line in 1997–1998 as thousands in the labour force lost their jobs.

In addition, the crisis also had political consequences, most notably the resignation of Chavalit Yongchaiyudh as the Thai prime minister to be succeeded by Chuan Leekpai, the leader of Thailand's Democrat Party (DP). The DP quickly implemented many of the neoliberal prescriptions of the International Monetary Fund (IMF), thereby bringing upon itself the wrath of many Thais, who felt that the Democrats were forsaking the country's interests and in particular, the needs of the poor and the vulnerable. Among other things, the IMF package called for significant reductions in government spending meant to contain the fallout, allowed insolvent banks and financial institutions to fail, and aggressively raised interest rates—a painful prescription by any measure.

In 1998, Thaksin founded the TRT as a populist party with a vision for reform at its very core. Its motto "*khit mai, tham mai*"—"think new, act new"—encapsulated this new reformist agenda. Initially, Thaksin had built his party's base around big business, bureaucrats and reform-minded

[8] The main differences were that civil society's bill would have been completely free, it would have merged all current government insurance systems, it would have applied to everyone including non-citizens; and would have ensured greater representation by civil society on the universal health care board (interview, Jon Ungpakhorn, 24 June 2009).

individuals, but by 1999 he realized that the severity of the crisis had opened up a reservoir of discontent—cutting across the middle class and the rural poor—that was waiting to be tapped. As criticism within parliament began to build against the DP's neoliberal policies, Thaksin entered the fray by juxtaposing his dynamic, entrepreneurial and nationalistic vision to the plodding and bureaucratic approach of Prime Minister Chuan.

While the crisis opened the door for Thaksin to challenge the DP-led government, simmering rural discontent that antedated the crisis created a wider opening for Thaksin's political strategy. By the early 1990s, rural unrest had increased sharply. Two factors had led to a sharp increase in protests by the rural masses. First, falling agricultural prices and rising debt had debilitated many villagers engaged in commercial agriculture. Second, political liberalization in the late 1980s had given rural people more space to voice their interests (Baker 2005: 118–19). One of the most significant elements of this rural unrest was the seemingly detached response of the DP.

Rather than focusing on the myriad problems of the rural countryside—ranging from agricultural debt to livelihood displacement due to dams and other development projects—Chuan and the Democrats dismissed the rural poor's concerns. Taking advantage of the increasing anger of rural organizations against the Chuan government, Thaksin then started meeting with the leaders of the Assembly of the Poor—a large and vocal civic group with rural roots. By the time the campaign for the 2001 elections had begun, Thaksin had fine-tuned his electoral strategy. In August 2000, he put forth the outline of what was to become his rural package—a populist platform devised with the support of various NGO leaders as well as student activists from the 1970s.[9]

This populist platform included numerous policies, but three were especially popular and formed the core of the pro-poor agenda: a debt moratorium for farmers, a One Million Baht Village Fund that was meant to jumpstart small-scale entrepreneurial projects and the 30 Baht Health Care Programme. The 30 Baht Programme was the centrepiece of the reform agenda. Throughout the campaign, the populist platform

[9] Phongpaichit and Baker (2004: 68–9); McCargo and Pathmanand (2005: 93–9).

was widely derided by economists and the 30 Baht Programme was seen as financially unviable and a reckless effort to pander to the electorate, particularly the rural sector.

The 30 Baht Programme was spearheaded within TRT by several reformist doctors who had been members of the Rural Doctors Society. These included Surapong Suebonglee and Prommin Lertsuradej. Surapong had been the editor of the bulletin of the Rural Doctors Society and a fellow contributor to the pilot Ayuddhaya Project, while Prommin had been a Vice President of the Rural Doctors Society. Both were now in Thaksin's inner circle (Harris 2015).[10] As the chief health policy adviser to Thaksin, Surapong invited Sanguan to meet with Thaksin and present his proposal for universal health care (Baker 2005). On 24 December 1999, Thaksin met with Sanguan and other members of the Rural Doctors Society, as well as with several of his close aides. Here Thaksin expressed strong support for a universal health care programme, suggesting that the programme be called "20-Baht cure all diseases"—rather than simply a generic universal health care programme—in order to make it more attractive (Harris 2015). Eventually, Thaksin and his advisers agreed that the programme would have a 30 Baht co-payment. Sanguan's original plan was to create a universal programme that would unify all of the public insurance programmes, but with clear resistance from civil servants and labour unions—the constituents of the CSMBS and the SSS, respectively—a separate 30 Baht Programme emerged (Towse et al. 2004).

The January 2001 elections saw an unprecedented victory for Thaksin and TRT. TRT dominated northern Thailand and won half the seats in the northeast—the country's two poorest regions. By absorbing the small Seritham Party soon after the election, and then taking in the medium-sized New Aspiration and Chart Pattana parties, TRT had an outright majority in parliament. Indeed, by 2002, TRT had established a grand coalition—something unseen in previous parliaments (Chambers 2005). With hegemonic control of parliament, Thaksin then presented and subsequently proceeded to implement his ambitious populist plat-

[10] Under Thaksin, Surapong became Deputy Minister of Public Health, while Prommin was made Deputy Prime Minister. As Harris notes: "While other professional groups may have had ties to political parties, none had so completely colonized a party's political platform by virtue of their connections and authority as respected executives of the Ministry of Public Health" (Harris 2015: 179).

form. Unlike populist leaders in Latin America in the 1980s, who also campaigned on a pro-poor platform, Thaksin immediately fulfilled his pledges to the poor.[11]

On 26 February 2001, Thaksin declared in parliament that "the universal coverage of healthcare policy was one of nine high-priority policies" (Pitayarangsarit 2004: 17). With the firm backing of the Permanent Minister (the top-ranking civil servant) at the Ministry of Public Health, the policy was immediately implemented in six provinces in April 2001. The second phase ran from June to October 2001, where 15 more provinces were included. In October 2001, the programme was extended to the whole nation except the inner Bangkok districts. By April 2002, all of the country was covered. Thus, just three months after winning the polls, TRT had begun to implement a programme for universal coverage, and about one year later the programme was operating in every corner of Thailand.

The process by which the 30 Baht Programme was rapidly implemented owes much to political and bureaucratic support. The Ministry of Public Health Permanent Minister Mongkol Na Songhkla, himself a former rural doctor, decided to jumpstart the programme despite the fact that it had not yet been passed by parliament. In doing so, he pre-empted even TRT. Harris has termed Mongkol's action as a "strategic weapon" wherein bureaucrats "create policies in the absence of legislation and … implement policy before it has become law as a pilot project" (Harris 2015: 169). Mongkol was concerned that if he did not act quickly, the programme might be stalled by second thoughts within the party or by the typically short life span of Thai governments. Surapong himself had floated a one-year rollout of the programme, while other reformists suggested three years (Harris 2015: 180).

The rapidity with which the programme was implemented surprised even its primary advocate. As Sanguan Nitayarumphong (2006: 95) noted: "I had never envisioned the 30-Baht Program's implementation occurring over such a short period of time, feeling a three-year time frame would be more appropriate. Indeed, such rapid and extensive changes inevitably generated criticism." Yet, consistent opposition from

[11] See Stokes's (2001) argument regarding policy reversals in Latin America.

conservative bureaucrats and the medical profession necessitated a big bang approach:

> Upon reflection, however, the fast-track approach was probably vital to the Program's survival … From the beginning, it sometimes seemed like we were in a race to get the policy in place before the opposition's mounting momentum could stop the new program in its tracks. The political leverage from the election victory which enabled the swift transition from a policy on paper to care in the hospital carried with it latent resistance from the election campaign. Many still saw the policy as unfounded, arguing that it remained nothing more than a populist scheme to secure votes … in just a short period of time, the 30-Baht Program became the most controversial public health reform program in Thailand's history. (Nitayarumphong 2006: 95–6)[12]

The 30 Baht Programme: Success and Discontent

The evidence of the positive impact of the 30 Baht Programme is especially clear if one looks at two key indicators: access to health care and per capita funding. Compared with earlier health insurance schemes for the poor (the low-income scheme and the 500-Baht Health Card), in which approximately 34 million people had been covered, the 30 Baht Programme expanded coverage to some 45.35 million people in 2002, thus covering 92.5 percent of the population. By 2013, 99.87 percent of the population was covered. After instituting the 30 Baht Programme, the number of uninsured steadily declined from 17 million before 2001 to 4.60 million in 2002 and just under 82,000 in 2013 (see Table 4.1).

Under the two previous insurance programmes for the poor, the Ministry of Public Health had established a capitation of only Bt273. By contrast, the CSMBS had the highest allocation in the budget, even though it comprised

[12] In stressing the importance of speed of implementation for the 30 Baht Programme, Surapong noted in an interview with Joseph Harris (2015: 180) that Chiang Mai University historian and prominent civil society activist, Nithi Eawsriwong, had urged in his column in the Thai daily *Matichon*: "If you don't hurry [to implement it], you won't be able to do it."

Table 4.1 Medical coverage in Thailand, pre-2001–2013 (million)

	Pre-2001	2002	2005	2008	2013
Low-income scheme (So.Po.Ro)	22	N/A	N/A	N/A	N/A
500-Baht Health Card	12	N/A	N/A	N/A	N/A
Social Security and Workmen's Compensation Fund	7	7.12	8.74	9.84	10.77
Civil Servant Medical Benefit	4	4.05	4.15	5	4.98
30 Baht universal health care programme (Gold card)	N/A	45.35	47.34	46.95	48.61
Total population	61	61.12	62.81	62.55	65.04
Uninsured	17	4.60	2.36	.52	.08
Percentage covered	72	92.47	96.25	99.16	99.87

Source: Author based on data from NHSO (2009a, 2014)

Table 4.2 30 Baht Programme capitation rates, 2002–2013 (in Baht)

Year	Capitation rate
2002	1202
2003	1202
2004	1308
2005	1396
2006	1659
2007	1899
2008	2100
2009	2202
2010	2401
2011	2546
2012	2755
2013	2755

Source: Author based on data from NHSO (2009b, 2014)

only 12 percent of the population. In 2002, this was about Bt2349 per capita per year. The SSS that covered formal labour had an allocation of about Bt1450 per capita per year (Jongudomsuk 2002). Under the 30 Baht Programme, the allocation of funding for the poor received a big boost. In 2002, the budget per capita for the 30 Baht Programme was set at Bt1202. In 2009, it rose to Bt2202 (see Table 4.2). This last allocation was 95 percent of what the NHSO requested (NHSO 2009b). The capitation rate has increased every year, although it remained stable between 2012 and 2013. Overall, there were huge strides in financing, from less than Bt300 in funding pre-2001 to the 2013 capitation of Bt2755.

Thus, on two fundamental aspects of equity—access and per capita funding—the 30 Baht Programme can be judged to be successful.[13] Furthermore, a number of studies have shown that the incidence and intensity of catastrophic payments for health care declined after the advent of the 30 Baht Programme (Somkotra and Lagrada 2008; Wibulpolprasert and Thaiprayoon 2008). The poverty headcount and the poverty gap have also declined following the 30 Baht Programme. One study concludes that: "the UC [universal coverage] policy implementation is a valuable social protection and safety net strategy that contributes to the prevention of financial catastrophe and impoverishment" (Somkotra and Lagrada 2008: 2027).

Another area where the impact of the 30 Baht Programme has been evident is in infant mortality decline. A study by economists from MIT and Harvard University based on a survey from 2001 to 2005 that cut across all 76 provinces of Thailand concluded that infant mortality had declined by 13–30 percent in about one year across the country. Over the same period, hospitalization usage increased for women aged 20–30 as well as children under one year old. The increase in hospitalization usage in rural areas is most likely a crucial factor in reducing infant mortality rates (Gruber et al. 2014).

However, there is one area where progress has been limited. On the question of redistributing resources—including capital and medical doctors—towards the rural sector, the end result has not been positive. The initial goal of the reform programme was to create contracted units for primary care (CUPs) that would control and disburse funding. Crucially, funding would be based on population size. This policy decision was intended to redistribute resources away from urban tertiary hospitals based in Bangkok and the central provinces and increase the capacities of rural district hospitals. A strategic decision was made to keep capitation payment lower than what independent estimates argued was necessary so that capitation-losing hospitals would not be able to fully cover staff salaries. Medical expenses and salaries would be included in the disbursal of funds. This strategy, it was hoped, would put pressure on the Ministry of Public Health and Civil Service Commission to reallocate medical posts so that they were more closely aligned with financial allocations. The assumption

[13] For an overall positive assessment of the program, see Damrongplasit and Melnick (2009).

then was that if funding were based on population size, this might lead to some medical personnel moving to rural district hospitals, which would now be receiving more funds. The financial constraint was to function as the incentive that would push doctors into the rural sector (Hughes et al. 2010: 449; Wibulpolprasert and Thaiprayoon 2008).[14] The new funding structure was thus intended to serve as a fundamental lever that would create a huge constraint on larger urban hospitals and thereby move doctors once and for all into the rural district hospitals. But such a strategy meant that a clear loser in the reform programme would be the large tertiary hospitals with their high salaried medical personnel. Indeed, these hospitals found themselves in a difficult financial situation because their allotment did not cover both medical costs and doctors' salaries. In the early months of the programme, hospitals in the central region were forced to ask for contingency funds from the Ministry of Public Health.

Inevitably, a counterreaction by urban doctors and conservative bureaucrats in the Ministry of Public Health arose preventing the new financing structure from taking hold. Conflict within the ministry eventually led to two financing schemes taking place. Both involved capital being disbursed at the provincial level. In the first scheme, called the inclusive model, provincial offices channeled the funds to CUPs, which were given discretion in deciding how the money would be spent. In the second scheme, called the exclusive model, the provincial office held the inpatient budget, granting the CUPs funds only for outpatient and prevention/promotion work. Initially, the provincial health offices were granted the right to decide how to allocate salaries within the budget—that is, whether to include it in the total funds disbursed or to a priori reserve a certain amount of funds for the salaries (Hughes et al. 2010: 450).

However, in 2002–03 the ministry decided to disburse funding for salaries at the national (ministerial) level, thereby reducing the amount available for medical costs, and weakening the incentive for doctors to move towards rural hospitals. Thus, the funding available to CUPs was reduced and limited to outpatient and prevention/promotion funds (Hughes et al. 2010: 450). Inpatient work would be reimbursed directly

[14] Also see interview, Dr Pongpisut Jongudomsak, director of Bureau of Policy and Planning, National Health Security Office, Bangkok (29 May 2006).

by the National Health Security Office, the bureau in charge of the 30 Baht Programme, which functioned as the purchaser of medical services. This financial model subsequently went through some more compromises, where capitation is considered along with the exclusive model, but overall, the model based primarily on capitation has been put aside.

The effect of the defeat of the original capitation plan is significant. It has blunted the goal of redistributing medical staff to rural hospitals. Since rural hospitals that serve larger populations are no longer prioritized in the funding scheme, there is no incentive for doctors in urban areas to move. Tertiary hospitals have thus gained because salaries have not been affected, while funding for universal care is balanced in their favour, rather than in favour of the hospitals serving larger population densities. Following this change, those hospitals that found themselves on the precipice were district or provincial hospitals in the countryside that were not receiving funds quickly enough to cover the increased demands for medical attention. According to the Rural Doctors Society, of 819 ministry-run hospitals, 265 had accumulated debts of Bt1.3 billion by 2004. Of these, only 19 were general and regional hospitals, while the remaining 246 were district hospitals mainly in the north and northeast—the poorer regions of Thailand (Kittikanya 2004). A research report by the National Economic and Social Advisory Council argued that the revised method of funding allocation was "unfair" because it placed the burden squarely on the shoulders of the rural hospitals where demand for the programme was high.

For their part, large urban hospitals argued that the per capita allocation that remained part of the funding process negatively affected their own budgets when district hospitals referred patients to the larger hospital. The initial costs that smaller hospitals had estimated would form the basis for reimbursement complicated the budget estimates of the larger hospitals. But the larger problem that has greatly troubled doctors at larger hospitals has been the concern over their salaries and of an unmanageable workload stimulated by mass demand (Thoresen and Fielding 2011).[15]

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[15] Also see interview, Dr Suthat Duangdeeden, physician at Lerdsin Hospital, Bangkok (16 June 2003).

Conclusion

Despite a counterreaction by conservative bureaucrats and doctors, as well as a barrage of criticism by economists and pundits concerned about the populist—and therefore allegedly reckless—elements of a universal health care programme, the 30 Baht Programme has become institutionalized in Thailand's political system. Its contributions to socioeconomic equity have been significant. First, it has succeeded in providing universal coverage to almost all Thai citizens. Those who were excluded in the past and now have health care include farmers, unskilled workers and shopkeepers. Given the high percentage of individuals in Thailand working in agriculture or the informal economy, and who are therefore self-employed, a universal coverage programme has made a huge impact. The few who are still not included are those who have not registered in their district.[16] Second, capitation spending for the poor has increased sharply because spending has increased yearly for the 30 Baht Programme. Third, the programme has prevented catastrophic income losses on the poor when they require medical intervention. Fourth, there is evidence that the programme has also helped lower infant mortality rates.

Lastly, perhaps less tangibly, but no less importantly, the 30 Baht Programme has fundamentally changed the discourse of pro-poor politics in Thailand. Not until TRT campaigned on, and then implemented, a programme of universal health care along with other populist programmes, had there been a serious effort to address the interests of the poor. The push for social reform in the health system has been present since the mid-1970s, but it was only through a party agenda that such reform could materialize. Although other programmes such as the debt moratorium for farmers and the One Million Baht Village Fund also advanced pro-poor reform, these programmes have been largely dismissed as quintessential dole outs. The same efforts to paint the 30 Baht Programme as populist pandering have, however, not succeeded. Thus, the very viability of the 30 Baht Programme has ensured that pro-poor policies do have legitimate space in the Thai polity. Since Thaksin was ousted in a military coup in September 2006, every subsequent govern-

[16] Hill tribes peoples are also not included.

ment has retained the programme. Indeed, the military government that took over in 2006 even scrapped the 30 Baht co-payment, arguing that it was an unnecessary bureaucratic transaction.[17] In 2006, the military furthermore elevated to the post of Minister of Public Health the former permanent secretary of the ministry who had been one of the strongest advocates of the 30 Baht Programme. "No government, politician, or party dares to stop this project," says Deputy Secretary General of the NHSO, Dr Weerawut Phancrut (Asia News Network 2015).

The failures of the programme, however, have also been notable. Most critically, the programme was unable to make significant headway in reversing the imbalance of medical doctors and resources that favours the urban sector. The instrument that was counted upon to redistribute doctors and resources was the allocation of funding. Based on the idea that money should follow the population, the reformist bureaucrats hoped that doctors would be pushed to move where more money was now being allocated. But from the very beginning of the programme it was difficult to force through such a radical funding scheme based simply on "economic levers" (Hughes et al. 2010). Within one year of the programme beginning, the conservative bureaucrats allied with discontent urban doctors had been able to reverse the funding scheme and return it to a situation that favoured the larger urban tertiary hospitals. As one study notes: "It was overly optimistic to think that capitation funding alone could achieve a major redistribution of resources and staffing when resisted by the medical profession and sections of the administration" (Hughes and Leethongdee 2007: 1006). Although population size still plays a role in calculating the funding allocation, it is not the primary variable in making this allocation, while salaries of the urban hospitals have remained well-funded—the key issue that stimulated the counterreaction.

What has plagued the universal health care programme has been a bureaucratic tug-of-war between, on the one hand, conservative forces seeking to protect their interests and, on the other hand, reformists within the ministry and in the core institution in charge of the 30 Baht Programme, the NHSO. This battle is in large part pure bureaucratic

[17] The co-payment was restored in 2012. The military most likely sought to undermine the programme's identification with Thaksin while appearing to be even more pro-poor.

politics. The advent of the 30 Baht Programme was a clear blow to the dominance of conservative forces at the Ministry of Public Health. The NHSO was put in charge of the implementation of the programme as well as its funding. The Ministry of Public Health remained the provider of health care services but did not have direct control over the 30 Baht Programme. As a result of this division of labour, the two institutions have been at loggerheads since the initiation of the programme.

Recent developments in Thai politics have also affected the prospective sustainability of the universal health care programme. Although the 30 Baht Programme remains in place in the wake of the May 2014 coup, it continues to be a target for conservative critics (Bangkok Post 2014). Crucially, the programme is linked in the popular mind to Thaksin—a deeply polarizing figure in a country now undergoing an unstable political transition. In the desire of the royalist and military forces to efface all remnants of Thaksin's legacy, one danger is that the 30 Baht Programme could find itself caught in the crossfire as collateral damage—undermined because of its political association and origins.

Yet, despite these challenges, the social and political forces backing the 30 Baht Programme are considerable. To undermine a programme that is now deeply institutionalized in the Thai health care system and in society at large would elicit great opposition. Perhaps even more fundamentally, the evidence of the 30 Baht Programme's record is quite clear. It is widely considered to be very successful, judged in terms of coverage, funding, impact on the incomes of the poorest groups, as well as effect on basic health indicators such as infant mortality rates. Numerous scholars and policy analysts across the world, as well as international organizations, now turn to Thailand's 30 Baht Programme as a model for reforming their health system.[18]

In the context of political turmoil in Thailand as well as the entrenched power of conservative bureaucratic forces, there have been inevitable setbacks to a reform programme as sweeping as universal health care. Yet, the very fact that this programme is still institutionalized and that it has many backers, both domestically and internationally, suggests that the

[18] For China's positive view, see Li et al. (2011). See also WHO (2010) and Amartya Sen, "Universal Health Care: The Affordable Dream," *The Guardian*, 6 February 2015.

political strategy of a big bang approach has paid off. At the same time, without the early efforts of reformist doctors associated with the Rural Doctors Society to lay the foundation for health care reform, the big bang approach would likely not have been as successful. Both institutional capacity and swift political initiative are necessary factors for spearheading and sustaining deep policy reform.

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5

The Impacts of Universalization: A Case Study on Thailand's Social Protection and Universal Health Coverage

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Introduction

In Thailand, the first national health scheme was launched in 1975. Over the 30 years that followed, the country had attempted to provide universal coverage of health protection, a goal which was finally achieved with the introduction of the Universal Coverage Scheme (UCS) — otherwise known as the 30 Baht Health Care Programme—in 2001. Prior to the UCS, various protection schemes were targeted in nature and only covered limited population groups. By the first year after its inception, by contrast, the UCS covered 47 million people—75 percent of the population. The remaining 25 percent belonged to other schemes, such as the Civil Servant Medical Benefit Scheme (CSMBS) and private sector employees who were covered by the country's Social Security Scheme (SSS). Thus, with the implementation of the UCS, the entire population has access to some form of health coverage.

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This chapter explores some of the lingering questions surrounding the nature of universal health coverage (UHC) in Thailand. It probes the impacts of the 30 Baht Health Care Programme objectives, related mainly to poverty and inequality. To do so, the chapter considers health policy as one part of a larger framework of social protection. Such an understanding of social protection systems and the stance of health policy within this framework requires an awareness of the institutional development specific to the national context. In this chapter, this awareness is developed through an analysis of Thai government processes for both planning and allocation of funds in order to understand the comprehensive outcomes linked to health policy.

In order to analyse the policy process and identify key drivers for the universalization of health care in the country, the chapter focuses on both direct and indirect impacts on programme objectives and on the structure of policy making. The chapter also considers how the extension of social security includes or excludes various stakeholder groups in the process of achieving the SSS question. Primarily, this chapter inquires how these processes affect stakeholder groups in Thailand.

The first section begins with a conceptual approach that offers guidelines to analyse the specific 30 Baht universal health policy in Thailand (described in the previous chapter of this volume). This is followed by a discussion of social protection and health care access in Thailand as well as of the health financing reform and the path towards UHC in the country. This allows for an analysis of the comprehensive outcomes of the UHC movement, differentiating between the direct and indirect impacts of UHC in the country.

Comprehensive Outcomes Framework: Processes, Institutions and Actors

Health policy needs to be seen in relation to other social policies, as health is affected by a wide spectrum of factors, and vice versa. These factors include aspects such as income, employment and access to education. A comprehensive outcome approach offers an expansive, yet intuitive lens to understand the impact of these relations on the universalization of health care.

A comprehensive outcome, referred to by Sen (1997, 2009), describes a state of affairs that can be rich, incorporating processes of choice and not only a narrowly defined ultimate result.[1] According to the "comprehensive approach", the content of outcomes can also be seen as including all the agency information that may be relevant and all the personal and impersonal relations that may be seen as important for resolving the problem at hand.

Sen pointed out that we care not just *that* we achieve what we want, but also *how* we achieve what we want. Comprehensive outcomes matter as much as culmination outcomes by considering the process taken to arrive at culmination outcomes, for example, regardless of what is expected from an intended agency or a range of valuable "functionings". Thus, a concentration on achieved results through a culmination of outcomes would consider the ultimate effect of policy on welfare; however, a reflection on comprehensive outcomes would consider whether the policy had been developed and implemented in a fair manner. The outcome of "fairly developed and implemented" is a comprehensive outcome, incorporating a deontological element within a consequentialist framework. Hence, the approach focuses on the deontological emphasis of actions (actions' adherence to normative rules), the functionings or the relations between outcomes, and institutional complementarity.

Through this comprehensive outcome lens, this chapter focuses on the relations between outcomes (for example, the generation of both intended and unintended outcomes) and the institutional complementarities that may exist. In Thailand, there is a conscription system that is embedded in the societal, economic and political fabric. This system plays a significant role in enhancing a rural resident's access to medical doctors since it can mobilize and dispatch medical doctors to rural areas, and, consequently, contribute to increasing the capacity of the medical care system in those areas under the 30 Baht health policy. The stance of comprehensive outcome focuses on this kind of interdependence between policies and institutional complementarity created in the process of development of the Thai health insurance system.

[1] This is also reflected in "culmination outcomes" that are detached from processes, agencies and relations.

Social Protection Categories

Comprehensive social protection can address health risks. Social protection is a set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation. The policies and programmes that comprise social protection serve multiple (and often simultaneous) roles and functions. When these policies and programmes are systematic and sustainable, they protect people from risks, hardship and insecurities related to poverty and to vulnerability, prevent people from falling into poverty, lift those in poverty out of it and contribute to socioeconomic security and overall well-being. Components of social protection include labour market interventions, social insurance, social welfare and safety nets.

This study distinguishes between two main aspects of social protection:

- *reactive* social protection that is put in place to cope with a major shock or vulnerability (for example, in response to a health scare or injuries);
- *proactive* social protection that aims to invest in people's social security and their ability to manage risks, enabling them to plan and be more productive in their livelihood.

When health protection is "reactionary", it is put in place out of a sense of urgency to cope with a major generalized shock or vulnerability mainly, for example, to respond to a disease. Such an emergency reaction lacks time for thinking and planning. A more "proactive" approach, which aims to invest in people's social security and their ability to manage risks, enables people to plan and be more productive in their livelihood. It is under this proactive approach that health protection can become a central element to reducing risks.

Different social protection programmes have different types of impact on citizens' health. Devereux and Sabates-Wheeler (2004) proposed a typology to distinguish between interventions (Table 5.1).

The implementation of Thailand's health schemes falls mainly into the protective programmes category. In the protective mode, the health

Table 5.1 Types of social protection programmes

Reactive	*Protective programmes* that offer relief to those with low levels of adaptive capacity through humanitarian support in emergencies and targeted cash transfer schemes
Proactive	*Preventive programmes* to prevent damaging coping strategies, particularly before a shock to avert deprivation or to mitigate the impact of an adverse shock. Examples include health and unemployment insurance and non-contributory pension schemes
	Promotion programmes to enhance resilience through assets, human capital and income earning capacity of the poor with skills training and active labour market programmes
	Transformative interventions[a] to address underlying causes of power imbalances that create or sustain economic inequality and social exclusion, aimed to transform social relations. Measures include legal and judicial reform, budgetary analysis and reform, the legislative process, policy review and monitoring, and social and behavioural/attitudinal change. Here, Mkandawire's (2004) concept of "transformative social policy" seems to be a more elaborated concept, which highlights the synergies between the economic, political and social determinants, and the developmental role of social policy in shaping non-state actors and markets in social provisioning

Source: Author.

[a]See Davies et al. (2013). Transformative social protection is grounded in social justice and seeks to address underlying causes of vulnerability beyond the provision of short-term relief from poverty or the management of risk. For example, social protection can assist in transforming social conditions by establishing certain rules, policies, laws and norms, such as minimum standard of working conditions, access to microfinance (particularly for children), minimum wages and inclusive policies. Most recent discussions on social protection examine the interface between social protection, minimum income and basic health insurance, emphasizing the provision of a core set of basic social services, a discussion associated with the social protection floor (ILO 2011). The transformative dimension suggests that there are structural barriers to livelihood security and there is a need to address the root causes of people's vulnerability

scheme aims to protect marginalized groups or individuals such as children, the elderly and informal workers. With regard to preventive programmes, Thailand has made some progress, but this has to be further developed. Under the introduction of the 30 Baht policy, payment is still used in a reactive manner for illnesses and injuries. Detail of this reactive mode is elaborated later in the chapter.

The promotive form of health protection can be considered at two levels: individual and state. At the individual level, with improved health care, Thai citizens have increasing resilience and protection against illnesses. There are also increasing resources available in hospitals, not only to deal with symptomatic cures, but also to provide advice in preventing diseases and promoting well-being. At this point, avoidance of health risks also depends on how the individual makes use of doctors and medical resources. While better-quality care is available for Thai citizens under the 30 Baht health policy, there are still instances where health care protection remains in the reactive mode, and often people use the 30 Baht health policy out of a sense of urgency rather than considering it as an assurance of health security.

At the state level, there are increasing efforts to enhance the resilience of the poor, in particular through productivity-enhancing programmes. As poor people experience better health, they are able to contribute more to the country's economy, thereby increasing overall labour productivity. Hence, the spillover effect of improved health care is maximized through the promotive programmes at the state level.

Finally, transformative intervention is merely incidental in Thailand. For instance, so far, there has been no explicit policy that addresses the heterogeneity of migrant workers; only a health security fund for those foreign workers covered by work permits.

For the transformative interventions to be effective, access and opportunities are needed for minorities in society to improve their social relations and be in a better position to secure health care for themselves.

Public Sector System of Provision and Thailand's Health System

The distinctiveness of Thailand's health system within social protection can be explained through the framework of Fine and Leopold's (1993) public sector system of provision, which focuses on the chain of provision from production, distribution and consumption at the empirical level. In Thailand, the consumption of health care has shifted from a "passive process", where a limited pool of citizens *reacted* to health risks, to

a gradual "active process", whereby a wider range of citizens can prevent their own health risks as well as respond to them with treatments. This transition is linked to how the consumption of health care is connected to the changing pattern of production and distribution of the health care system. Access to early intervention and preventive support, which were not previously financially accessible, have been key to this change.

When considering distributional outcomes in terms of spending, it is evident that the 30 Baht health policy has contributed to the expansion of the public sector system of health provision. Even if the public structure of provision, which is heavily reliant on government revenues, is subject to decreasing private health care spending, the tension between public and private service providers persists, as seen, for example, in the case of medicines quality. Consumers are aware of the lower-quality brand of medicines used under the 30 Baht health policy due to the constrained public budget. Thus, those who can afford it opt for private provision of health services.

As a result, while the state's role in health provision under the 30 Baht health policy concerns distributive and social justice outcomes, the consumption pattern specific to the 30 Baht policy shows a disproportional representation of women, children and the elderly. Another problem in shaping the unequal consumption is the rural–urban divide in health service provision. Given the number of available hospitals and health care workers, access to health services in rural areas is still more limited than is the case in urban and central areas. Also, the 30 Baht policy is a geographically registered programme. A large proportion of migrant workers who moved from rural areas to the central city of Bangkok cannot access health care services in the city as they had previously registered to the 30 Baht scheme in rural areas. It is estimated, for example, that 72 percent of internal migrants working in Bangkok bought their own medicine because their 30 Baht eligibility was recorded in another town (Daily News 2013). Since 2012, the National Health Security Office (NHSO) has allowed workers to move their 30 Baht eligibility more frequently, from two to four times per year, so that they can use health care services closer to where they work. However, many members are still unaware of this possibility and the process may still be cumbersome for some (ASTV Manager Online 2012).

Social Protection and Health Care Access in Thailand

Historical Development of Social Protection in Thailand

Prior to the 1997 financial crisis, Thailand demonstrated a case of a residual developmental welfare state in which income protection was not provided to the informal sector and assistance benefits were only offered at a rather low level. Since the crisis, social protection in Thailand has evolved from its subordination to economic development to a broader support for local development and the increasing inclusiveness of the informal sector. The financial crisis paradoxically played an instrumental role in the formation of Thailand's current structure (Tivayanond 2011).

Before the financial crisis, the Thai developmental state was characterized by export-led economic growth. Like many other Asian countries, this economic growth in terms of aggregate gross domestic product (GDP) was the fundamental goal, being prioritized over social development.[2] The precedence of export-oriented economic development meant that social protection covered mainly civil servants and workers in the formal sector, mainly those employed by large companies. These social protection schemes included the Civil Servant Pension Scheme, Social Security Fund and Provident Fund that were offered by the public sector and large-scale corporations (Pongsapich 1999). Meanwhile, there was an absence of social protection for those informally employed who largely relied on the family and community network (Parnwell 2002). As soon as the Asian financial crisis hit Thailand in 1997, the harsh reality of loss of income and unemployment for workers in the rural economy made the impact of the absence of social protection heavier (Table 5.2).

Following the financial crisis, changes slowly emerged in the form of normative and institutional shifts towards broader support for local development and increasing inclusion of the informal sector. The government seized new grounds by introducing the dual-track policies of social protection and economic development. The impact of the financial

[2] Chang (2003), Kwon (2005), Wood and Gough (2006).

Table 5.2 Social protection schemes in Thailand

Coverage	Before the 1997 crisis	Between the 1997 crisis and the 2008 crisis	Since the 2008 global economic crisis
Formal sector: private and government sectors[a]	Provident Fund Civil Servants Pension Scheme Social Security Fund	Social protection as found before the 1997 crisis	Social protection as found after the 1997 crisis
Informal sector and non-government sector	Social Security Act 1990 Benefits covering sickness, disability, death, childbirth, old age and child welfare. (Unemployment benefit was drafted in the Social Security Act, but it was not implemented) Labour Protection Act 1998 Workmen's Compensation Fundb Severance Payc Provident Fundd Employee Welfare Funde	Additional schemes such as dual track policies: One Tambon One Production Village and Urban Revolving Fund[f] Three-year debt moratorium Small and Medium Enterprise Bank 30 Baht health policy	Additional schemes: Universal tax-financed 500 Baht ($18) as income security for elderly over age 60 Revision of Social Security Act Article 40 of voluntary package covering sickness, invalidity, death and old age pension (lump sum amount)g National Savings Fund for Thais aged 15–60 where members contribute monthly; depending on amount contributed (ceiling of 600 Baht or $18) and age, members will benefit from a contribution from the government

Source: Authors' analysis from documentary data and interviews

[a]Government programmes include protection for employees of government and government enterprises. Social security was provided for employees in the private sector, but managed by a government agency. Contributions to the Social Security Fund come from employees, employers and the government. Civil servants and employees of government enterprises were eligible for benefits in terms of pensions and health care for self and family members. Pensions for civil servants are for life, while compensation for employees of government enterprises vary from agency to agency. (The Labour Protection Act B.E. 2541, 1998, Government of Thailand Department of Labour Protection and Welfare, Bangkok. Accessed 9 March 2015. http://www.labour.go.th/en/attachments/article/18/Labour_Protection_Act_BE_2541.pdf)

(continued)

Table 5.2 (continued)

[b]Employers contribute to the fund to provide compensation for employees in case of sickness, disability or death caused by injury at the workplace (Labour Protection Act B.E. 2541, 1998)

[c]Severance pay is provided to employees upon termination of employment (Labour Protection Act B.E. 2541, 1998)

[d]The fund includes contributions by both employers and employees as a protection in case of retirement, death, termination of employment, or termination of membership of the fund. The Provident Fund Act 1987 states that the Provident Fund is voluntary and not required of all firms (Labour Protection Act B.E. 2541, 1998)

[e]The Employee Welfare Fund was established to provide welfare for workers terminated from employment because of death or other reasons. Both employers and employees are required to make contributions to the fund (Labour Protection Act B.E. 2541, 1998)

[f]The loan portfolio totalled $4.9 billion in 2011 with a network of nearly 8000 village banks. Villagers are eligible to take out loans limited to 20,000 baht ($656) without collateral. The scheme has drawbacks, including strict regulations and licensing requirements (T.F.J. 2013)

[g]Only 1.68 percent of the informal worker sector is covered so far (ILO Social Protection Country Profile, Thailand. Accessed 5 March 2016. http://www.social-protection.org/gimi/gess/ShowCountryProfile.action?id=404&lang=EN)

crisis was so grave it prompted the necessity of change and the need for policies in both these areas, consisting of the Village and Urban Revolving Fund, the "One Tambon One Product" scheme, and the 30 Baht health policy (OSMEP 2007). These new policies aimed to address the problems of slow capital accumulation and economic downturn within the country. At the same time, the dual-track policies (Brown 2003) were also intended to raise the level of productivity within the local economy. In the case of the 30 Baht health policy, health coverage for those belonging to the informal sector was a primary concern for attribution. The fact that better health behaviour is correlated with lower workplace absenteeism and higher productivity was generally accepted across Thai society.

Health Financing Reform Towards Universal Health Coverage

Health Financing Development in Thailand (Prior to Universal Coverage)

Even before the introduction of the 30 Baht health policy (subsequently changed to the Universal Health Coverage Policy), many health insurance and assistance programmes and schemes had been implemented since 1975 (Pramualratana and Wibulpolprasert 2002). The Medical Welfare Scheme (MWS) was established to exempt the poor from user fees at government health facilities with funding from the government budget. The programme subsequently expanded to cover the elderly, children and other socially deprived groups. Although helpful, the programme suffered from ineffective targeting and was seriously underfunded. Beyond the MWS, there were other health insurance and government welfare schemes for formal sector employees. The CSMBS was established in 1980 to cover civil servants, public employees and their families. The SSS for private employees was first introduced in 1990. Efforts to expand coverage to informal workers and their families were made with community financing schemes in 1983, which were later nationalized into the Voluntary Health Card Scheme (VHCS) in 1991. The VHCS was later discontinued due to the problem of adverse selection that derived from its voluntary nature.

Since the early 1990s, there have been regular debates and discussions about how to improve efficiency in the health system and expand health care coverage to the informal sector to achieve UHC (Hanvoravongchai 2013). It was clear to policy makers and technocrats that relying on the VHCS or existing schemes (CSMBS, SSS or MWS) to expand their coverage to the uninsured population would neither be feasible nor successful. The UCS was therefore created for the non-CSMBS and non-SSS population in 2002. The pattern of health insurance expansion from 1991 to 2009 in Thailand is shown in Fig. 5.1.

One precursor to the development of the UCS was the World Bank Social Investment Project that was implemented in Thailand between 1998 and 2001 (Hughes and Leethongdee 2007). A payment reform was piloted in six provinces to test demand-based financing system based on population size, upon which the 30 Baht health policy was built. Instead of providing budgetary funding to public sector health care providers based on its size, staff number and historical performance as was previously the

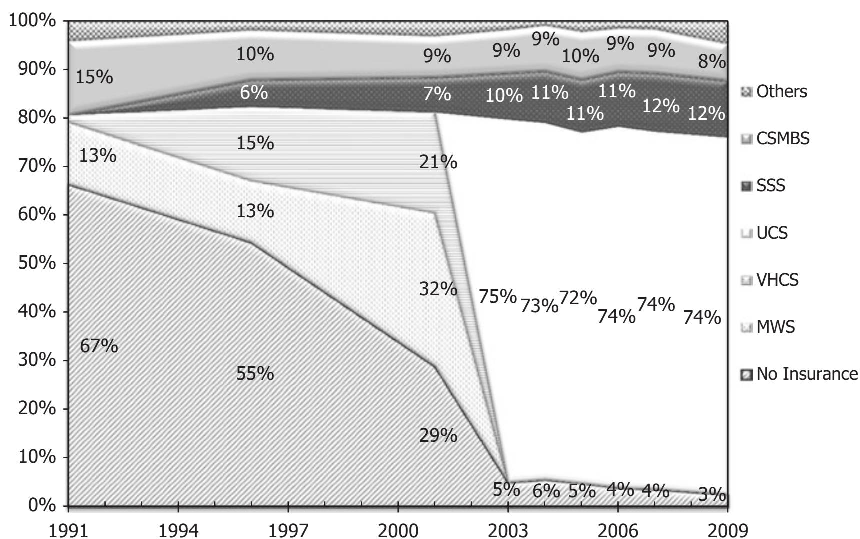

Fig. 5.1 Health insurance coverage by insurance scheme, Thailand, 1991–2009
(*Source*: Author based on data from HISRO 2012)

case, the 30 Baht health policy introduced a capitation payment (cost per beneficiary) that pays providers based on the number of people under their responsibility, called the Contracting Unit for Primary Care.

Universal Coverage Scheme Reform and Implementation

The UCS was officially and institutionally established when the 2002 National Health Security Act was promulgated.[3] According to the Act, "the Thai population is entitled to health services, the standards and efficiency of which are outlined in the Act". A new, independent organization, the NHSO, was created to serve as a state (autonomous) agency under the authority of the National Health Security Board (NHSB). The "types and limits of health service for [UCS] beneficiaries" and provider payment methods are prescribed by the NHSB, while the NHSO is responsible for the beneficiaries and service providers' registration, the fund's administration and provider payments.

Thai nationals who are not already covered by the CSMBS or SSS are eligible for the UCS. The UCS benefits package is comprehensive and includes inpatient and outpatient care, prevention, promotion and rehabilitation, dental care, maternity care and delivery, home health care and prescription drugs. UCS beneficiaries are restricted, however, to health care services from the specific health care provider network with which they register. This "gate-keeping" mechanism allows members to use health care services with very minimal or no co-payment, but in the case of health care providers outside the network, they must pay out-of-pocket themselves (except in the case of emergencies).

In addition to health care coverage expansion, the UCS also introduced two major health financing reforms in the Thai health care system: a *purchaser and provider split* and *strategic purchasing* (HISRO 2012). The UCS, with the NHSO as its purchaser, contracts with health care providers, both public and private, to provide health services for its beneficiaries. This meant a major shift in the health financing authority

[3] National Health Security Act B.E. 2545 (A.D. 2002), NHSO. Accessed March 2016. http://www.nhso.go.th/eng/Files/Userfiles/file/Thailand_NHS_Act.pdf.

from the Ministry of Public Health (MOPH) to the NHSO. Many MOPH administrators perceived this change as the UCS undermining the role of the MOPH as the steward of the health system (Treerat and Ngamarunchote 2012).

Purchaser and Provider Split

In the past, the MOPH was both the budget holder and provider. However, after the introduction of the UCS, the MOPH and its network of hospitals and health care providers became the main contractors for the NHSO. The contractors can have subcontractors, such as private clinics or health centres, to provide primary care and preventive and promotive health services. The NHSO also has contracts with private hospitals, even though the number of these declined continuously due to relatively low capitation and case-based payments system. In addition to hospital contracts, the NHSO also contracts directly with private clinics in Bangkok for primary care.

Strategic Purchasing

Under the UCS, the NHSO channels the funds to the contracted providers using several active purchasing mechanisms. Capitation was for outpatient care and diagnosis-related groups (DRGs) with the global budget cap for inpatient care. In addition, the NHSO also employs additional funding mechanisms. High-cost cases such as heart attacks or strokes that require specific instruments are paid for by using a pre-assigned fee schedule. Fee schedule payments are also used for priority services and specific diseases to increase access to services such as cataract surgery, kidney stone treatment, HIV/AIDS and renal replacement therapy. The complex payment mechanisms and the proposed budget for each payment item for 2013 is summarized in Fig. 5.2. The use of different payment methods for various interventions was designed to introduce different incentives for providers.

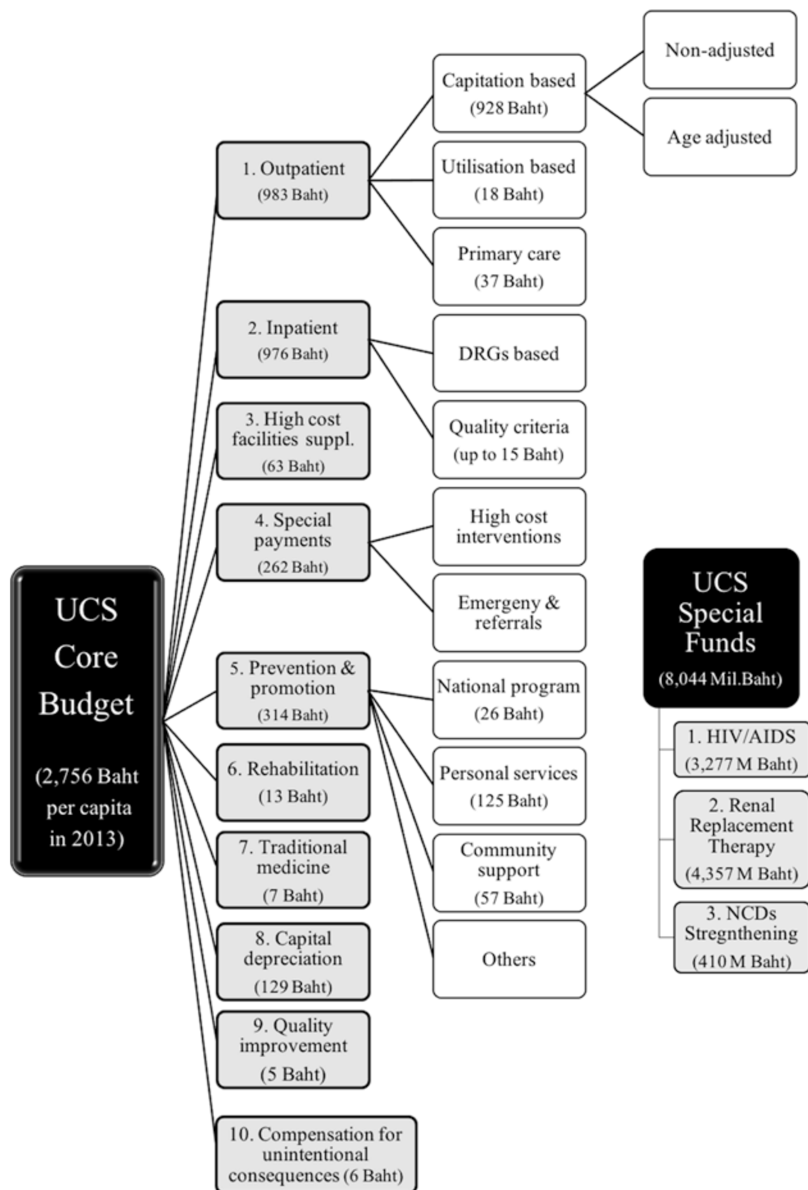

Fig. 5.2 Payment mechanisms and budget for different benefit types under UCS. Notes: *NCDs* non-communicable diseases. NHSO administration costs not included
(*Source*: Authors' analysis. Data from NHSO)

Health Financing Situation After the Universal Health System

The UCS implementation changed the landscape of health care financing in the country. Public sector financing for health, mainly from government revenues, became the most important funding source for health care in the country. The amount of public health spending increased continuously and the share of private financing in total health spending declined (Figs. 5.3 and 5.4). Out-of-pocket health spending was less than 15 percent of total health spending in 2010, while government expenditure on health grew by almost 10 percent annually on average from 2001 to 2010 (Hanvoravongchai 2013). The share of government health spending in total health spending increased to around 80 percent in 2013 (Fig. 5.3). Health financing from the UCS increased from about 15 percent in 2003 to 22 percent of total health spending in 2010 (Fig. 5.4). Nevertheless, the proportion of GDP spent on health showed

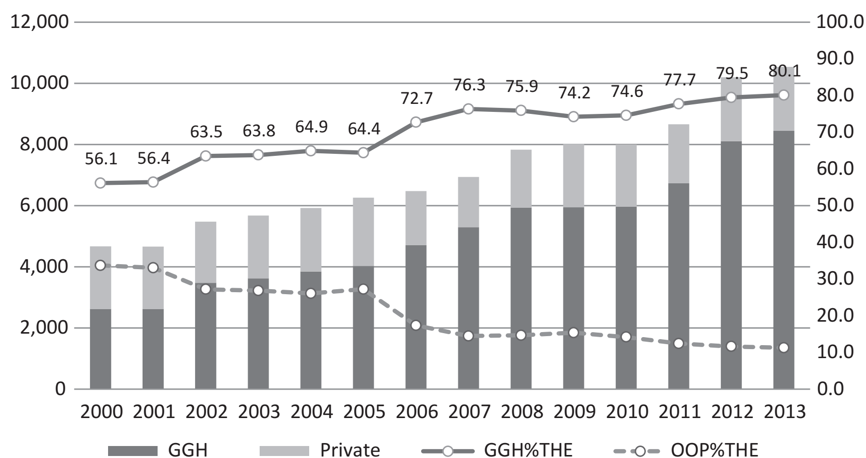

Fig. 5.3 General government expenditure on health and total health expenditure in Thailand, 2000–2013.
Note: *GGH* general government expenditure on health, *PVH* private expenditure on health, *OOP* out-of-pocket, *THE* total health expenditure. Expenditures are shown in million constant 2005 US dollars
(*Source*: Data from the World Health Organization Global Health Expenditure database)

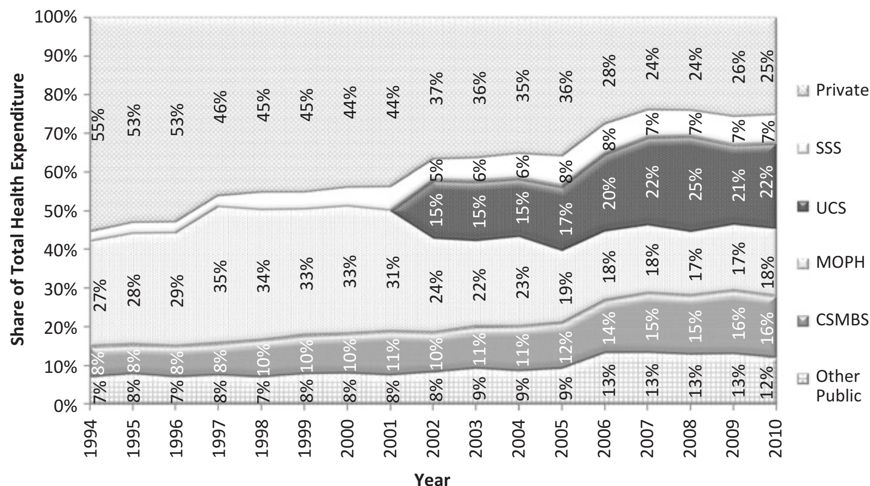

Fig. 5.4 Share of health financing in Thailand from variety of public and private sources, 1994–2010
(*Source*: Data from Thailand NHA 2011 Working Group 2013)

little increase, remaining at around 4 percent. The health financing reform accompanying the establishment of the UCS also had significant impacts on the health care financing functions and health system arrangements, which will be further discussed later in this chapter.

Comprehensive Outcomes of the Universal Health Coverage Movement

To assess the comprehensive outcomes of the UHC movement in Thailand, it is necessary to look at the intended impacts of UCS implementation on health care access, utilization and financial protection against excessive health care payments. The broader effect on health outcomes of the population beyond health care should also be evaluated. The UHC movement has direct and indirect impacts on other health financing schemes and health system functions beyond the UCS as it influenced the institutional, process and outcomes of a broader range

of social protection movements in the country. This section describes the results of our review of the outcomes of UHC in Thailand from its implementation in 2002 to the time of writing.

Direct Outcomes of UCS Implementation

The implementation of the UCS to expand health service coverage was a major step in Thailand's social protection movement. To date, a number of studies have been conducted to evaluate the outcomes of UCS implementation within the dimensions of health care access and health care utilization, protection against excessive out-of-pocket health care payments and improving population health outcomes, which are the main objectives of the UCS.

UCS Outcome on Health Care Access and Health Care Utilization

Based on an evaluation of the UCS in 2011 by a group of independent international experts (HISRO 2012), the introduction and implementation of the programme has improved health care utilization, as shown by Fig. 5.5. Although overall outpatient and inpatient services among UCS members, in particular outpatient service, did not increase much at the beginning of the programme (NHSO 2012), the utilization rate rose steadily after implementation with outpatient visits per person increasing from 2.45 to 3.23, and inpatient admissions per person increasing from 0.094 to 0.114 (Fig. 5.5). One major contributor was the expansion of outpatient service provision at health centres and district hospitals. A recent study to evaluate the impact of the UCS on health care utilization and access using a quasi-experimental method found that the programme reduced the probability of foregoing formal health care when ill by 11 percent and increased the opportunity of inpatient admissions by 18 percent, with the greatest effect of outpatient care access on the poor and rural population (Limwattananon et al. 2013).

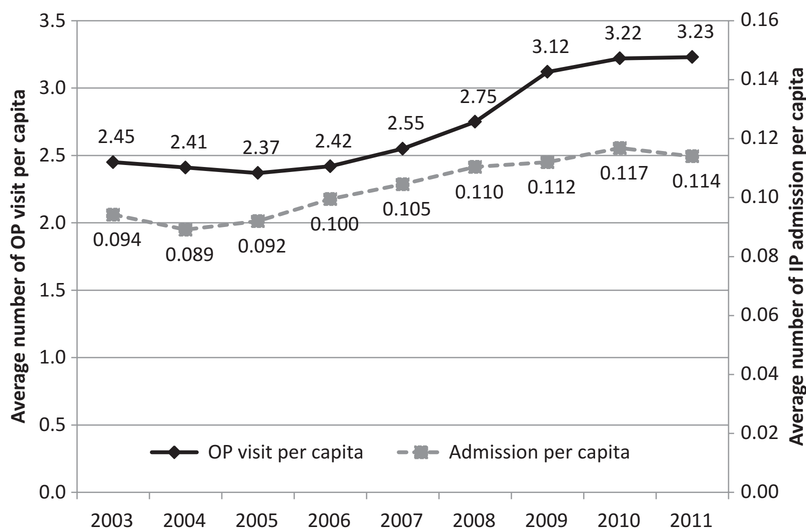

Fig. 5.5 Changes in health care utilization rate among UCS members, 2003–2010.
Note: *OP* outpatient, *IP* inpatient
(*Source*: Data from NHSO 2012)

Limwattananon et al. (2012) studied the difference in the outpatient and inpatient utilization between the poorest and richest quintiles and found significantly higher levels of use by the poorest group. As shown in Fig. 5.6, the poorest group's shares of outpatient and inpatient utilization in total utilization are higher than the proportion of UCS members in the poorest group, reflecting higher use. However, the analysis did not control for the probability of illness that is generally higher in poorer populations.

One criticism from sceptics of the UCS in comparison to previous health welfare programmes for the poor concerned its plausible shift in subsidy to the better off, given that all population groups are covered by the scheme rather than it specifically targeting the underprivileged. On the contrary, a benefit incidence analysis of government subsidies to the UCS by Limwattananon et al. (2012) found that a greater proportion of the subsidies went to the poorest group rather than the richest. The availability of an extensive network of public health care providers at the district level

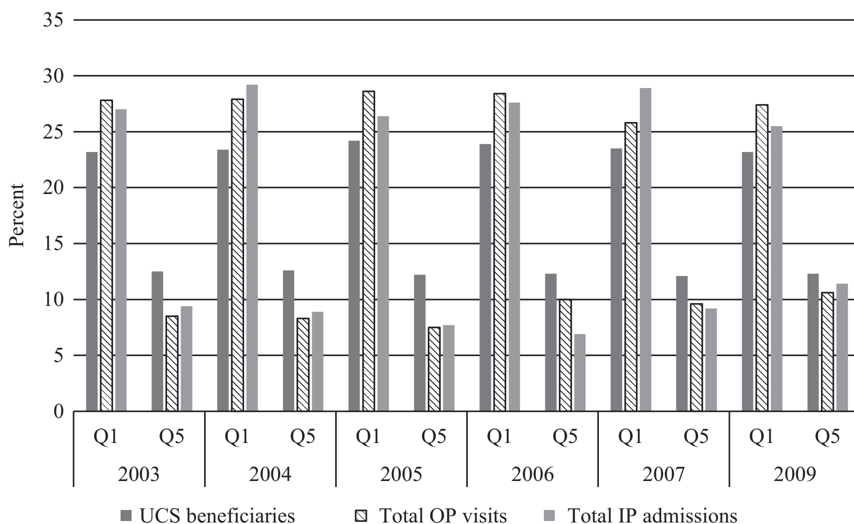

Fig. 5.6 Proportion of UCS members and proportions of their outpatient and inpatient utilization comparing richest (Q5) and poorest (Q1) quintiles, 2003–2009. *OP* outpatient, *IP* inpatient
(*Source*: Data from Limwattananon et al. 2012)

and little or no co-payment are considered major contributors towards pro-poor subsidies of the UCS, even without targeting. In addition, since richer populations, who can afford to pay out-of-pocket privately, tend to choose private clinics or private hospitals to avoid long queues for public facilities, the pro-poor subsidies are more likely to reach the poor. This indirect pro-poor effect, however, may pose longer-term problems to the UCS because it may lose broad national support, especially if it is perceived as a low-income programme with poor-quality care.

UCS Outcome on the Protection Against Health Spending Shocks

In addition to reducing financial barriers to access to health care, another main purpose of health insurance is to help protect individuals and households from financial shocks due to health care payments when obtaining health care services. Two widely used measures in the assessment

of financial protection from health care payments are the proportion of households with catastrophic health spending[4] and the proportion of households who become poor because of health care payments.

A number of studies found that the incidence of catastrophic health spending from health payments decreased after the introduction of the UCS.[5] As shown in Fig. 5.7, the proportion of households with catastrophic health spending (defined using a 10 percent threshold level) declined compared with the period before the UCS. The reduction occurred in almost all economic groups with a higher reduction among the UCS members in the poorest quintile. The proportion of households facing impoverishment due to medical payments also decreased in 2002 and 2004 when compared to the proportion prior to UCS in 2000

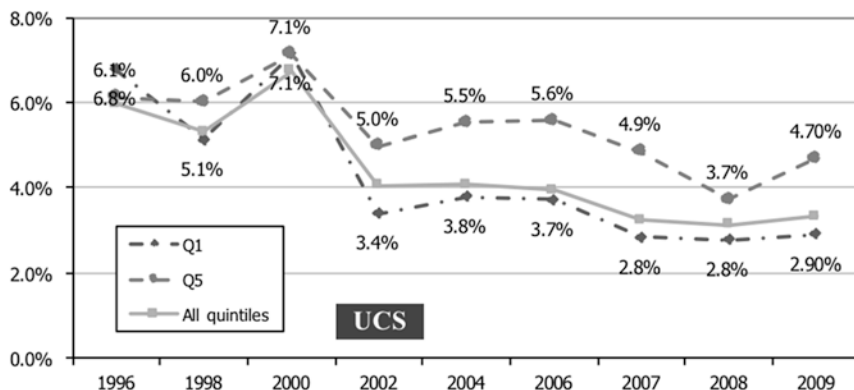

Fig. 5.7 Proportion of households with catastrophic health spending by quintiles, 1996–2008.
Notes: Household catastrophic health spending is defined as the level of health spending higher than 10 percent of total household consumption. Q1 is the poorest quintile
(*Source*: Modified from HISRO 2012)

[4] Catastrophic health expenditure is usually defined as having out-of-pocket payment for health exceeding a threshold level (for example, 10 percent) as a proportion of household income (usually measured using total consumption expenditure). Household impoverishment from health spending is defined as households whose income (consumption expenditure) level declines below the poverty level because of health spending.

[5] Somkotra and Lagrada (2009), Limwattananon et al. (2007), HISRO (2012).

(Limwattananon et al. 2007). An analysis presented by HISRO in 2012 estimated that from 2003 to 2008, more than 100,000 households were prevented from impoverishment due to out-of-pocket health care spending (HISRO 2012) (Fig. 5.8).

UCS Outcome on Population Health

The main goal of the health system is the improvement of the population health status, as measured in a number of outcome indicators. Unfortunately, the NHSO did not regularly evaluate the change in health outcome of its members so it is impossible to assess the impact of UCS on population health. Data from the World Development Indicators showed a continuously declining trend of neonatal, infant, child and adult mortality after the introduction of the UCS. However, it would be difficult to attribute these changes solely to the impact of the UCS given its declining trend prior to the introduction of the programme and the potential effect of many other contextual factors. Nevertheless, recent evidence showed that the introduction of the UCS has increased health

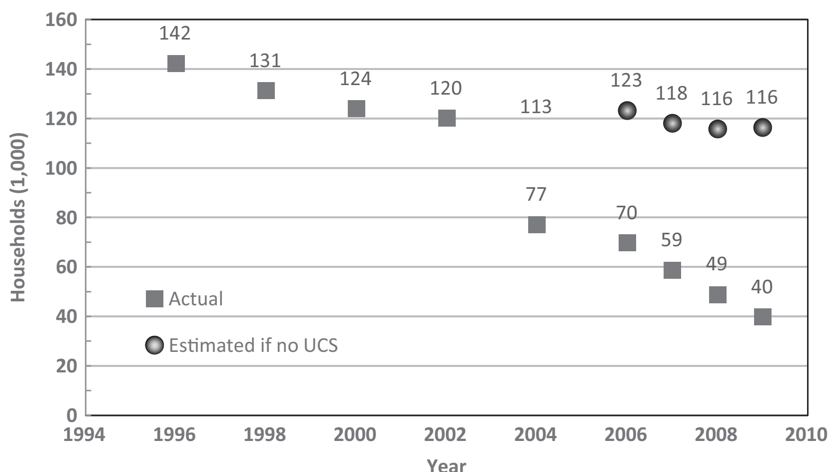

Fig. 5.8 Estimated number of households impoverished from health care payments and the estimated trend if there were no UCS
(*Source*: Modified from HISRO 2012)

care utilization, especially among the previously uninsured, resulting in a significant reduction in their infant mortality, after controlling for other factors (Gruber et al. 2014).

Indirect Effects of UCS Implementation

In addition to direct outcomes of health insurance expansion on health care access and financial protection against catastrophic payments, there are other indirect outcomes of the UCS beyond these goals. These indirect effects can be aimed at the health sector as well as beyond it, as described below.

A Paradigm Shift Towards Thinking About Health Care as a Basic Right

One of the major paradigm shifts as a result of the UHC movement in Thailand is the change in public thinking about access to health care. Prior to the establishment of the NHSO and UCS, health care was mainly an individual or family responsibility unless they were covered by health insurance provided through their employment (CSMBS or SSS) or they purchased private health insurance. The government provided support to the poor and other disabled or underprivileged groups through the MWS that exempted them from user fees at publicly owned health facilities only. People viewed government provided health care as public welfare or charity and had no voice over the quality of services they received. The introduction of the UCS changed the perception of the public towards health care as the citizens' right. Everyone has the right to quality health care and because the public felt ownership of the programme, they were more likely to express their opinions over how health care should be provided (see, for example, Prachathai News 2012). Many civic groups were formed and have been very vocal in the health policy directions of the UCS (HISRO 2012). Publicly provided health care is no longer a social assistance programme operated and controlled by the government, but one component of a publicly financed health care scheme to ensure the right to health care for everyone.

The shift toward the right-to-health paradigm does not happen without concerns or criticisms. There are concerns from some population groups about the imbalance between civil responsibility and welfare dependency as a result of free health care programmes, who argued that the interest in self-care and healthy behaviour could be jeopardized and the costs to society in the long run may be unaffordable (Na Ranong and Na Ranong 2002). So far, there have been no studies to demonstrate such negative implications. However, members of other contributory health insurance schemes such as the SSS also requested lower or no contributions given that UCS beneficiaries do not need to pay premiums or contributions. More discussion about this is provided in the section on indirect effects of the UCS on social security expansion below.

Further Emphasis on System Accountability

The change from a welfare approach to a rights-based approach means that the health care system needs to become more responsive to the needs of the population. At the same time, the NHSO and public health providers need to be more accountable to the public. The demand-side financing approach requires hospitals and health care providers to be more user oriented in their operations given that their funding is more dependent upon the users and patients. This is a major change from the system prior to the UCS when the top-down approach in financing and authorization often served central bureaucratic interests rather than population demands.

A number of systems and programmes have been implemented to monitor and improve public accountability of the NHSO (and UCS) and health care providers. For example, there are five representatives from civil society organizations on the NHSB.[6] The NHSO also has an external

[6] According to the National Health Security Act, five members of the NHSB are self-elected from representatives of non-governmental non-profit organizations working in the following areas: (i) child and youth affairs; (ii) women's affairs; (iii) elderly affairs; (iv) disabled or mental health related affairs; (v) HIV/AIDS or chronic disease conditions; (vi) labour related affairs; (vii) slum affairs; (viii) agricultural affairs; and (ix) minority affairs.

monitoring system to evaluate its performance every year in relation to a number of key performance indicators. The results are then reported to the NHSB for system improvement (NHSO 2012). The UCS also contains a system to allow for complaints and appeals from its members or contractors. A telephone hotline was set up for questions and complaints from the public. Another safeguard system for health care users integrated into the National Health Security Act is a no-fault compensation policy for health care related injuries and deaths. This provision aims at reducing the trend of medical litigation that had been increasing in Thailand over the last decade. The UCS also indirectly supports the introduction and implementation of the hospital accreditation system.

Decentralized Financial Management and Outcome-Based Payment

As described earlier, the emergence of the UCS was accompanied by major financial reform in the Thai health system. The purchaser–provider split and strategic purchasing of health care services allowed the financial system in the public health care sector to shift from inputs-based financing to a more decentralized financial management system based on outcome-based payments. Hospitals can then use the revenues from the UCS for hospital operations and maintenance. Such an increase in the financial autonomy of the public hospitals allows them to better respond to the demands for health care from their population. Some hospitals, with increased funding under the new payment system, are enabled to improve their health care infrastructure to expand health care services. This would not have been achieved so easily in the previous top-down budgetary system where the process required many steps of approval. Most public hospitals with staff shortages due to a zero-growth policy in the public sector (an ongoing civil servant system policy since 2006) can hire more staff as hospital employees to ease the workload. This adjustment in health care staff in the public sector is discussed further below.

New Culture and Mechanisms to Promote the Use of Evidence for Health Policy Decisions

The establishment of the UCS and the new financial management system after health care reform also required good intelligence for policy decision making in many areas. At the start of the UCS, it was necessary to know how many people were still not covered by any major health insurance. To carry out strategic purchasing, the UCS required an extensive information system for beneficiary registration, benefit decisions, health care processes and output monitoring and evaluation, and health care payments. The NHSO relies on several existing and specifically established organizations and internal information management to fulfil its information needs. They also contributed significantly to the evidence generation and the development of a better information system in the health sector. Two specific areas are discussed here: health information and research system development, and health technology assessment.

Health Information and Research System Development

The need to expand coverage to the population not already covered by other schemes led the NHSO to work with other stakeholders in order to improve the Ministry of Interior vital registration system and birth registry, and better capture the entire Thai population. With the identity (ID) card and the unique ID number system developed in 1984 prior to the existence of the UCS, the NHSO works with the Department of Provincial Administration to use the demographic information provided in this database for member registration. The UCS also adopted the national ID card as its membership card, so all individual level information is linked to the unique ID numbers. In addition to routine information system development, the NHSO also contributed to further research on health financing and health service system development.

Health Technology Assessment for UCS Benefits Decisions

Even though the UCS is relatively comprehensive, it does not cover services for all available technologies and medicines. The NHSO frequently receives more requests to include new health technologies, medical interventions, medicines or biologicals in the benefits package. In this regard, the NHSB Committee on Benefits Package is in charge of revising the benefits package and making recommendations to the NHSB on the adoption of new drugs and technologies. Prior to 2010, there were no systematic and transparent mechanisms to make such decisions (Jongudomsuk et al. 2012). Recently, a guideline was developed and evidence such as the effectiveness, cost effectiveness and budget impacts of various technologies and health interventions are required in the consideration of benefits package expansion (Fig. 5.9). Overall, the UCS contributed significantly to strengthening the health technology assessment capacity in response to demands for evidence on benefits package decisions.

Better Distribution of the Health Workforce for a More Equitable Health System

With the rapid expansion of coverage and the increase in health care utilization, the initial phase of the UCS saw higher staff workloads that demanded rapid adjustment from the health care providers in order to satisfy the increase in health service needs. This exacerbates the challenges in the Thai health workforce system that had long suffered shortages and distribution problems of its skilled workforce before the introduction of the UCS. With the change in payment mechanism towards more strategic purchasing, demand-side financing was expected to help improve the situation of the health workforce, especially in the rural and deprived areas. By initially including salary as a part of the capitation rate in 2002, health care providers in rural areas with larger populations and health care needs, would have received higher total budgets to increase the number of staff. However, due to the rigidity in the civil service system and its

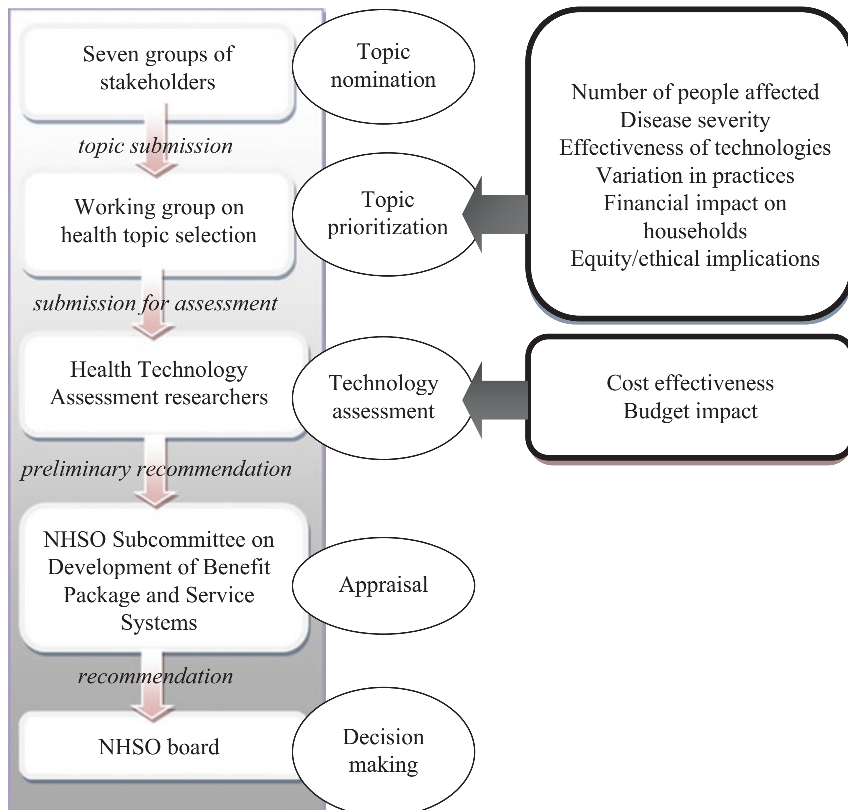

Fig. 5.9 Schematic diagram of the benefits package decision process since 2010 (*Source*: Modified from Teerawattananon 2012)

zero-growth policy, the number of health personnel posts in the public sector was heavily controlled, making it difficult to increase staff positions in those areas.

Nevertheless, it was found that the increase in financial autonomy at the hospital level from the UCS payment system allowed many health care providers to better respond to the increase in health care utilization in terms of health workforce productivity. Many public hospitals were able to provide additional compensation for higher workloads of their current staff. In areas where there was a staff shortage, temporary hospital staff were hired using hospitals' revenue from the UCS, a response to

mitigate the impacts of the "zero-growth" policy in civil servant positions. It was found that the proportion of the temporary health professional workforce to civil servant health professional workforce increased to much higher levels in the provinces of the northeast region where health professional densities were much lower than in other regions.

Lower Share of Investment in Health Promotion and Prevention

The UCS not only covers medical care, but also designates part of the capitation budget for health promotion and prevention. A number of programmes have been implemented, including a special fund to provide incentives for diabetes and hypertension screening and care. It also gives financial incentives to providers if they complete prenatal care services to pregnant women according to protocols. The NHSO works with local governments to set up jointly funded sub-district health funds to support locally driven public health activities or programmes (Srithamrongsawat et al. 2010). Despite such investment, the overall impact on prevention and promotion was not satisfactory. Overall funding for public health and disease prevention as a share of total health spending initially declined. The focus on curative care means relatively less investment in public health functions (Srithamrongsawat et al. 2010).

Impacts on Other Health Financing and Slow Expansion of Social Security Coverage

The approach of strategic purchasing adopted by the NHSO and its implementation indirectly influenced other major health insurance schemes to be more active in their purchasing. For example, in 2012 the SSS considered and implemented a DRG-based payment system for inpatients (SSO 2011). The UCS also indirectly guided the decisions on benefit packages for other health insurance schemes. For example, the UCS expansion to cover renal replacement therapy and antiretroviral treatment influenced the SSS to expand those benefits for their beneficiaries.

The UCS may also have a negative influence on social security coverage. Prior to the establishment of the UCS, coverage of social security was expanding slowly. The introduction of the UCS and its free health care reduced the incentives for individuals to enroll in the SSS for medical benefits. The proportion of the population with SSS coverage, therefore, remains at about 11–12 percent. The effort to expand SSS coverage to spouses and children of its members was not attractive given that they were already covered by the UCS. By contrast, there had been political requests by several groups to opt out of the SSS.

Comprehensive Outcomes of Thailand's Public Sector System of Provision for Health Care

Increased health care utilization among the previously uninsured is one of the dominant intended outcomes of the transition toward UHC. As follows, the UCS prompts the need for coordination between government units, namely the MOPH and NHSO, in order to extend coverage. The shift in the health financing authority from the MOPH as the budget holder and providers to the NHSO has undermined MOPH administrators as the stewards of the health care system.

In addition, the Thai experience of UHC resulted in relatively lower financial allocation in health promotion and prevention as funding went into medical care in the financing system. The central role given to curative care means that there are fewer projects for preventing infection transmission or in understanding the risk of infection and control. Allocation of the fiscal budget also diminishes in terms of health promotion, leaving a smaller budget for other government units working in this area. Efforts for prevention and raising awareness can be found, for example in the Thai Health Promotion Fund, which is an independent state agency funded by the surcharge tax of tobacco and alcohol excise taxes.

Under the politically driven process, the tendency to build health care infrastructure has been evident since 1975 when the MWS was first introduced to exempt the poor from user fees at government health facilities. Additional health schemes for civil servants and the VHCS also paved the way for the UCS in Thailand. In addition, investment

in health infrastructure continued during and after the Asian financial crisis of 1997. Amidst political changes in the country, the UCS was introduced in 2002 by the Thaksin Shinawatra government.

At the participatory process level, the convergence of political commitment and civil society mobilization paved the way for the UCS in 2001. Civil society had a vital role in setting the agenda and participating in the legislative processes. In October 2000, a group of Thai non-governmental organizations led by Senator Jon Ungphakorn supported UHC and drafted a National Health Security Bill (Evans et al. 2016). This initiated the process of convincing people that UHC was financially and programmatically feasible.

At the institutional level, the rollout of the UCS influenced the slow expansion of health insurance under other schemes such as the national SSS, given that attention to health welfare was encapsulated under the 30 Baht health policy. Before the UCS, it was intended that social services provision, including the health system, should be under the national SSS. While progress in health care is seen as more evident under the 30 Baht health policy than under the country's SSS, the benefits of health care coverage curbs other benefits that should be covered under the national SSS. For example, with the provision of the UCS there is less necessity for the SSS to include good health care coverage. Even those who are entitled to health insurance under the SSS have opted to access the 30 Baht health policy instead. This means less attention and, therefore, less improvement in government action programmes that are intended to promote the welfare of the population through assistance measures or other social protection, suggesting institutional disjoint.

Also, at the institutional level, health care quality improvement through the hospital accreditation system entails increased accountability of the system. Public interests matter because subsequent allocated funding depends on the number of users and patients. The formation of an external monitoring system of civil society representatives helps push the NHSB toward system improvement. Responsiveness toward health care needs has improved.

The UCS has led to an improved database for the informal sector. Since the UCS requires added input of those who are not covered by major health insurance, it prompts an information system for beneficiary registration and output monitoring and evaluation. In addition, knowledge of health care processes and the informal sector becomes more integrated. The need

for the NHSO to work with the Bureau of Registration Administration and the Department of Provincial Administration suggests increasing scope for cross-policy learning and capacity development among government units. This opportunity allows for upgraded knowledge and skills and awareness of gaps as well as best practice across units.

Conclusion

The 30 Baht health scheme (or UCS) has expanded coverage from those insured by civil servant insurance schemes and big corporations to those previously without insurance schemes, mainly informal sector workers. The UCS now includes informal sector workers and provides protection to those who were previously uninsured, who now have better access and financial protection from health care payments. Universal provision suggests a certain number of rights of health care for these groups. Before this universal provision, health protection was a privilege for those who could access health provisions. Ultimately, the UCS changed the thinking about health care provision by the government from social assistance to a right.

Meanwhile, unintended consequences of the UCS reflected the unequal access of health care provision for migrant workers. So far, the demands of health service providers in the government and the private sector who serve migrant workers and illegal immigrants have grown in order to cope with increasing numbers of migrant workers.[7] The risk of the spread of communicable diseases means that hospitals have had to provide migrant workers with medical treatment despite the lack of provision of health welfare for these migrants. Meanwhile, many health facilities face financial crises as they must treat migrant workers who do not have a work permit and who do not contribute financially to the Thai health system. Health services for these people become a burden and require adjustment. The need for the Thai government to adapt to this requirement parallels the growth of the Thai economy, which is largely supported by the work of migrants. Migrant workers contribute around 7–10 percent of

[7] Many migrant workers in Thailand come from Cambodia, the Lao People's Democratic Republic and Myanmar. There are an estimated four million legal and illegal migrant workers in Thailand (National Health Commission Office of Thailand 2012).

the value of Thailand's industrial sector, 4–5 percent of the agricultural sector and an overall 6.2 percent of the country's GDP (National Health Commission Office of Thailand 2012). In 2012, an estimated 520,000 migrant workers bought an exclusive type of health insurance offered only to migrants, which is rather low considering that there is an estimated 2.4 million non-Thai migrants living in the country (NESDB 2012). Limited knowledge about this type of programme prevents migrant workers from buying health insurance. Thus, the government still must consider how to expand social protection coverage and address the salient risks of illness of migrant workers, which may not have been a pertinent issue previously. The recognition of the need to extend the thinking on health care coverage not just for Thais, but also for non-Thais, itself indicates an expanded awareness of social risk protection.

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6

Political and Institutional Drivers of Social Security Universalization in Brazil

Marcus André Melo

Introduction

In Latin America, 19 countries have included the right to health in their constitutions. The question is, however, not the mere rhetorical adoption of the right to health in constitutions and political discourse but the practical implementation of this ideal. The case of Brazil is of particular interest because it seems to be the country where this constitutional ideal has been implemented most forcefully, and it has made significant progress towards universal social security by establishing a system to provide universal access to health care to its citizens.

Reformers in Latin America and elsewhere have recently drawn inspiration from the Brazilian case in the wake of the unprecedented recognition of the international development agenda that universal systems are crucial to overcoming poverty and reducing inequality (Rodin and Ferranti 2012). While the organization and structure of the Brazilian

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social security system and its achievements and constraints are relatively well known, less attention has been given to explaining the institutional and political drivers towards the universalization of health security in the country. Although its accomplishments have been widely acknowledged, the system has been under considerable stress in recent years. How did this system come to enjoy such legitimacy and what makes it politically and institutionally viable? Several contributions have described the historical conditions leading to the establishment of the Unified Health System (*Sistema Unificado de Saúde,* SUS) and many focused on the role and the contribution of the *Movimento Sanitário*, a movement of health professionals, as the origin of the system (Faletti 2010). The literature has also investigated the governance mechanisms and the role of civil society in the workings of the health councils (Faletti 2010). This chapter reviews the institutional and political drivers of universalism, focusing on the factors that made the system currently in place both politically and institutionally viable: the nature of political competition in the country; a shared belief in social inclusion and universalism; issues such as institutional and organizational capacity; and the creation of fiscal capacity for the operation of the universal health system and more generally of a universal social security system.

Throughout this chapter, the term "universalism" is used liberally to indicate impersonality, coverage, non-conditionality and the formal entitlement to free-of-cost services depending on the issue area under discussion: pensions, social assistance or health. In the case of health, which is the focus of this chapter, it means that people have a formal entitlement to free health care provided by the state.[1] Importantly, the notion of universalism has been subject to considerable conceptual "overstretching" and is the cause of great confusion. In addition to a lack of clarity, the notion of universal access or coverage in the areas of health care, pensions and social assistance tends to have a different meaning. In the area of pensions, it is typically understood to mean that all people

[1] The *World Health Report 2010* defines the principle in *prima facie* similar fashion: universal health coverage as a target in which "all people have access to services and do not suffer financial hardship paying for them" (WHO 2010: 9). But this definition involves a consideration of capacity to pay that is absent from the former definition. As is demonstrated in this chapter, this has produced some perversity in the SUS system.

have access to universal flat pensions irrespective of past contributions (administrative or actuarial universalism). This is the strong version of universalism in pensions, which in practice means that additional coverage beyond a certain limit would be provided by private insurance. A weaker version of universalism in social security holds that pensions are granted according to the same rules irrespective of occupational status but are conditional on past contributions. In middle income countries such as Brazil, this would require the equalization of benefits across rural and urban groups and within urban groups across public sector employees and other special categories. In this version—a Bismarckian or corporatist model—labour market inequalities are reproduced in the pension system, but this would be the only acceptable inequity in the system. Thus, the level of the ceiling, in practice, determines the private-public mix or the extent of "de-commodification" in the system. In social assistance, the language of universalism is typically associated with the extent of coverage and access for the poor, the elderly and those excluded from the labour market. The key element in this case is impersonality and non-discretion. Thus, this definition does not restrict universalism to policies that are not conditional on the beneficiary meeting certain requirements—a usage usually found in the social policy literature. Universalism in this literature describes a situation where the entire population is the beneficiary of welfare benefits as a basic right, as opposed to targeting, which involves some kind of means-testing to determine the "truly deserving".[2]

How this formal entitlement translates into actual practice is conditional on a variety of factors, including health facilities, which may reflect inequality in other relevant dimensions. With regard to pensions, universalism is a commitment to eliminating inequalities and privileges of various types, while in the realm of social assistance it is a commitment to eliminating any conditionalities in accessing publicly provided goods and services. In this chapter, in general, universalism refers to the absence of discretionary criteria replacing need as the basis of entitlement.

[2] See Skocpol (1991), Antonnen (2002), Mkandawire (2005) and Antonnen et al. (2012). Social security is also a contested concept with regional variations in the usage of the term. Whereas in the US it refers primarily to old age, survivors and disability insurance, and welfare, in Europe as well as in Brazil, after 1988, it denotes social assistance, pension provisions and health care.

Towards Universalism: Democracy, the Constitution of 1988 and the New Social Contract

Universalism in social policy was part and parcel of the Brazilian developmental process whereby it became a foundational principle, although not fully implemented, especially in areas such as pensions. Indeed, this is enshrined in the constitutional principle that health is a right of citizens and an obligation of the state (Constitution of 1988, Articles 6 and 196). In this section, I show that the right to health stipulated in the Constitution has far deeper implications than simple access to goods and services provided by the state. The adoption of universalism in many areas of welfare provision is intertwined with the transition to democracy in the country. The development of Brazil's welfare regime can be explained, therefore, as a process where welfare and democratic regimes are interlinked. The empowerment of large electorates and a level playing field have indeed created strong incentives for the expansion of health care and social transfers (Rudra and Haggard 2005; Mares and Carnes 2009).

Brazil formally started its transition to democracy in 1985, when military rule gave way to civilian rule amidst a period of intense political mobilization. In the wake of a protracted transition process, which contrasted with other countries in the region, a complex bargaining process took place in which reformist political elites played a crucial role. Democratization was made possible as a result of an inter-elite pact. A coalition of centre-left and centre-right political forces dominated the transition agenda.

The new democracy's policy agenda was shaped by a policy-making process marked by the legacies of the bureaucratic authoritarian military regime (1964–1985) and a long tradition of political opposition. This opposition was characterized by collective endeavours and consistent criticisms that were largely (but not exclusively) from opposition circles of professional and intellectual elites. In this process, the opposition groups regarded the country's so-called "social debt" as a result of excessive bureaucracy, an extremely centralized decision-making process, the permeability to sectoral interests and, last but not least, a tendency

of public policy towards excluding the needs of the poorest members of society. For the new reform agenda, social inclusion and redistributive issues became key priorities. At a more specific level, this agenda addressed an array of issues related to the modus operandi of public policies and proposed changes. Lack of participation and "transparency" in policy making were viewed not only as having caused a structural bias in favour of middle-income groups, but also having contributed to the business groups' capture of resources allocated for the provision of public goods and services. Gigantic bureaucracies were seen as groups pursuing only their narrow organizational interests and dissipating public money. Decentralization and participatory practices were thus proposed as a means to overcome these problems. A new political coalition was formed, consisting of the urban middle class, the Catholic Church, trade unions, civil society groups, business groups and alliances between the Brazilian Democratic Movement Party (*Partido do Movimento Democrático Brasileiro*) and the Liberal Front Party (*Partido da Frente Liberal*).[3]

Reformers advocated a number of *idées forces*: democracy and popular participation, decentralization, and, above all, giving priority to the social agenda and inclusion, which meant in practical terms universal coverage of social security. A strong consensus among social actors emerged, leading to what could be called a new social contract in this context. Although the concept of a social contract implies a choice by each country regarding the way of organizing itself, it is in effect the result of a process of social choice that aggregates individual preferences in the context of specific political institutions, which are in turn endogenous to the social contract. In other words, the social contract determines the institutional choices made (Alston et al. 2013). The Brazilian social contract is encapsulated in the new Constitution of 1988, which was a critical juncture in the evolution of the Brazilian system of social protection. One of the most important innovations in the Constitution is the move towards what is called in this chapter a special type of "universalism" in which coverage is extended to reach all members or at least very large groups in the population as

[3] The *Partido do Movimento Democrático Brasileiro* was the main opposition party under the dictatorship and the *Partido da Frente Liberal* was founded by a group of defectors from Arena, the party that supported the military regime.

opposed to being targeted at specific clienteles, such as certain occupational groups or privileged groups. To argue that universalism has been an underlying leitmotif of the Constitution does not mean that the system of social security currently in place in Brazil is without certain privileges or inbuilt inequalities in terms of processes and particularly outcomes. Although privileges within the system have been gradually eliminated, certain categories of beneficiaries—public servants and specific categories of workers—have continued to receive special treatment.

Prior to the 1980s, the system for social protection was highly fragmented. In its formative years, it provided social protection—pensions and health care—to a few urban occupational categories. Under military rule, the system was overhauled and was partially consolidated. The systems for pensions and social assistance were fragmented and the rural poor and the urban informal workers were excluded from social protection, although some initiatives extended coverage to rural labourers in the 1970s. Access to health care was even more limited. Workers in the private formal sector of the economy with health insurance had very limited access to health care through private and public hospitals. The first attempt to rationalize health care under the social security system involved the creation of the *Instituto de Assistência Médica da Previdência Social* (INAMPS) in 1977, a public organization under the jurisdiction of the Ministry of Health, which took charge of managing health care provision. However, the system was chronically underfunded, restricted in coverage and mainly limited to emergency room care.

The reform agenda in the 1980s reflected a widespread recognition of the existing system's clear failures in many senses. Reformers consisted of a loose coalition of academics and professionals (some of whom were elected as members of Congress), civil society activists and government officials who pushed for an agenda based on three pillars.

First, a number of constitutional provisions extended care to the previously excluded social groups to guarantee universal access. The Constitution contained a strong statement that recognized health as a universal right of citizens, and obliged the government to provide universal and equal access to actions and services for health promotion, protection and recovery (Brazilian Constitution of 1988, Chap. 2, Article 196). The Constitution mandated the equalization of the rights and benefits of

rural and urban workers in the social security system. Based on this, for the first time, rural benefits were upgraded to the level of urban pensions (Melo 1993; Barrientos 2013). Not only was the minimum pecuniary value of pensions set at that of urban pensions and benefits and scaled up to the level of the minimum salary, but a whole range of benefits that had only been available to urban workers was also extended to rural workers. As a consequence, rural benefits were upgraded to reach the minimum salary. For health care, the main practical implication was that access to the system would be granted to all citizens irrespective of previous contributions or occupational categories or urban/rural status.[4] The new Constitution also resulted in the massive extension of effective health care coverage to rural workers through various mechanisms of primary care.

Second, unifying the system was seen as a precondition for the implementation of these constitutional provisions because there was a consensus that a fragmented system could not be used as a basis for universal coverage. In practical terms, this required the organizational overhaul of the system. In the case of the pension system, it meant that the existing stratification of benefits and eligibility criteria should be equalized. The major organizational innovation was the phasing out of INAMPS, with its function transferred to the Ministry of Health. In unifying the fragmented health system, the government gave priority to preventative care measures, with all the decisions made based on the epidemiological profile of the population.

The third pillar was a growing consensus around the lack of resources, the unsustainability of a purely contributory system and the necessity to allocate resources from the earmarked taxes for guaranteeing the universal component of social security, which required the overhauling of the funding mechanism. In addition to workers' and individual payroll contributions, new sources of finance were introduced. New taxes—the so-called social contributions—were created. They included a new tax on total revenue or turnover—the *Contribuição para o Financiamento da Seguridade Social*—and a new social contribution on net profits—

[4] Interestingly, most urban unions—along with senior bureaucrats in the planning and finance ministries—opposed this move, arguing that it might jeopardize the financial basis of the system, but it was strongly supported by the Confederation of Agricultural Workers (*Contag*) and by reformist legislators and bureaucrats.

the *Contribuição Sobre o Lucro Líquido*. This innovation had a symbolic importance because it signalled a break with the contributory principle informing the functioning of the extant system.

Although the new democratic Constitution embraced the principle of universalism and extended social rights significantly, it also confirmed existing privileges. It maintained a dual pension system with a pillar for private sector workers and the salaried and a separate subsystem for public employees. Inequality in the provisions of pensions in the two systems remained intact. Public employees also managed to secure privileged civil service status in the pension system and the benefits of civil servants (a full replacement rate for pensions and tenure status, among others) and 300,000 workers with contracts in the public sector (the so-called *Consolidação das Leis do Trabalho* contracts) were increased. This resulted in a significant actuarial deficit in the system because it created an inconsistency between past contributions and current pensions and a potential gap between insufficient current contributions and future pensions.

Several important changes in the welfare system accompanied the transition to democracy and even preceded the promulgation of the Constitution. The new civil government of José Sarney (1985–1990) created the Unified Decentralized Health System (*Sistema Unificado e Decentralizado de Saúde*, SUDS) and introduced several changes in the health care subsystem, including the elimination of barriers to entry for the non-affiliated poor.[5] However, the crucial move was the creation of the SUS in the Constitution, which aimed at universalizing access to health care and improving its quality, for example, through a more decentralized and participatory delivery of services. The constitutional provisions affecting the social security systems included a number of far-reaching measures (Articles 201 and 202), which were implemented by a host of organic laws, including: the Health Organic Law (Law 8080/1990) and the Social Security Organic Law (Law 8212 and Law 8213/1991).

[5] Previously, patients had to produce proof of an employment relationship prior to being admitted to the system.

In sum, the implementation of the SUS occurred in three phases. First, before the formal creation of the SUDS (the system that preceded the SUS) in 1985, some initiatives were implemented selectively in a number of municipalities under the Integrated Health Activities (a federal programme). This involved a shift towards increased outpatient care, the more efficient use of INAMPS facilities and some degree of decentralization. Interestingly, this was a time of intense social mobilization by health professionals, experts and professional unions known as the *Movimento Sanitário*. This movement was highly successful in transforming grassroots support into policy and institutional change. The apex of this mobilization was the Eighth National Health Conference, when a motion calling for health as a citizens' right and a public responsibility was approved, opening the way for the approval of a similar proposal during the workings of the Constituent Assembly (1987–1988). In the second phase, INAMPS was converted from a dual financer/provider role to solely a financing agency, access to INAMPS funding was universalized and INAMPS staff and facilities were transferred to state health secretariats. These changes occurred during the 1988–1989 period, before the promulgation of the Health Organic Law. The last phase essentially involved the transfer of public responsibility for health care to the municipal level (Paim et al. 2011). This was accompanied by the creation of municipal and state health councils with broad representation from health care users, providers and workers, and strong connections to policy makers. Weak at the beginning, these councils mushroomed across the country and over the last two decades have been strengthened and become key actors in health policy making and implementation.

President Fernando Henrique Cardoso (1995–2002) changed the Constitution so as to make social security more equitable. This was the first important reform of the system put in place as a result of the Constitution (Melo 2003). These parametric reforms of pensions made the system marginally more equitable and were approved as Constitutional Amendment 20/1998, which eliminated many distortions regarding replacement rates, special privileges and minimum age requirements for salaried workers in the private sector. Nonetheless, it was up to the Lula government (2003–2010) to introduce ceilings in public sector pensions (Constitutional Amendments 41/2003 and 47/2005). The subsequent

Rousseff government (2011–2014) further provided the enabling legislation that made the new complimentary system—the *Fundo de Previdência do Servidor Público*—effective (Law 12618/2012). Despite the existence of two subsystems in the current pension system in the country, this last step was an important move towards universalism understood in terms of equalizing benefits in the system.

Unanticipated Effects of Universalism

Has the formal entitlement to free health actually been translated into better access? According to data compiled in the World Bank authoritative report (Gragnolati et al. 2013), the answer is a qualified yes. In 1981, 49 percent of the population reported that social security or INAMPS was their "regular source of care", while another 19 percent reported that they relied on the public system or free philanthropic care. By 2008, only 58 percent of individuals reported being regular users of the SUS. As the report concludes, "if measured based on self-reported 'regular sources of care', the goal of bringing a larger share of the population into the public health system has not been achieved. However, other evidence suggests that nearly all Brazilians use SUS services at some point, including a recent study indicating that nearly 90 percent of the population uses the SUS exclusively or in combination with the private sector" (Gragnolati et al. 2013: 6). However, poor service has become an increasingly salient topic in political agendas, reflecting the ongoing inability of the system to effectively guarantee access.

However, there is evidence that the system has failed in several aspects, an outcome that is partially unanticipated. Despite the much-enhanced coverage, it remains uneven, inequitable and characterized by their poor quality. About one-third of the population does not receive even one consultation per year, and the SUS system covers a smaller share of health costs in the lower than in the middle and upper deciles of the income distribution (Ter-minassian 2013). Richer households resort to SUS services for the more costly specialized treatments, while using supplementary private health insurance for basic consultation and exams (Medici 2003; Mobarak et al. 2011). Simultaneously, private health plans have mushroomed in the country in the last decade, reflecting an exit movement by users from the SUS system due to quality issues.

One unanticipated outcome of the constitutional right to health is that citizens have resorted increasingly to the judicial system to ensure costly treatment that is rationed because of the universal and free-of-charge nature of the system (Menicucci and Machado 2010). Richer patients are more likely to know about new procedures and drugs and, therefore, have the resources to seek legal injunctions. This has caused considerable financial stress on the SUS. While there appear to be no figures available for this issue for the whole country, in the state of Rio Grande do Sul, Biehl et al. (2009: 2183) found that in 2006 alone 6800 medical–judicial claims reached the Attorney General's Office, an increase from 1126 in 2002. By 2008, a monthly average of 1200 new cases were reaching the office. This study found that in 2008, USD 30.2 million was spent by this state of 11 million people on court-attained drugs for about 19,000 patients. This represented 22 percent of the total amount spent on pharmaceutical drugs that year and some 4 percent of the state's annual projected health budget. Significantly, one-third of the total spent on court-attained drugs is for high-cost drugs not provided through the public health care system (Biehl et al. 2009: 2183).

As a result, this mechanism ends up reproducing inequality within the health system. The source of the problem is the inconsistency between an open-ended service package and the reimbursement of a limited list of services within the system. Patients litigate to have access to services not on the SUS list. Providers seek injunctions against private insurers in court with the requirement to reimburse the SUS for the cost of services provided to SUS patients, based on the principle of universal coverage.

Explaining the Political, Institutional and Fiscal Sustainability of Universalism

Brazil's transition to democracy was associated with an important change in mass beliefs. As argued in Alston et al. (2013), inclusion and universalism became part of the language of politicians and the organizing principle of political life. The Constitution encapsulated these new beliefs, but this has also been true for other constitutions in the Latin America region. What factors explain the emergence and the sustainability of these beliefs and ultimately, one decade later, the widespread

universalistic outcomes? Many countries have introduced innovations in social policy only to discontinue them later.[6]

One crucial question, then, is what explains the viability of the reforms that were undertaken. In this section, I argue that there are three crucial factors: political incentives, fiscal capacity and state capacity. Savedoff et al. (2012) made the point that all countries that successfully managed to guarantee universal health care have combined political mobilization with pooled compulsorily extracted funds and an increase in incomes. Political mobilization is indeed crucial. Nonetheless, this framework fails to take into account the incentives arising from electoral competition in new democracies.

Political Incentives for Universal Social Security

A crucial factor explaining the move towards a universalistic welfare regime is the existence of political incentives for power holders. Political competition for the median voter in a new democracy provides a powerful incentive structure. Competitive elections will lead newly enfranchised citizens to massively support redistribution and inclusion, and social security clearly plays a crucial part in this process. Figure 6.1 shows the rise of a mass electorate in Brazil. It shows the extension of the franchise that took place with democratization and the evolution of the proportion of total population that effectively voted for president and Congress between 1894 and 2006. Only in 1985 did Brazil authorize the right to vote for the illiterate, so the first time that a majority of the Brazilian population voted for president occurred in the 1989 election. The previous presidential election had been almost 30 years earlier, in which less than 20 percent of the population voted. Although Congressional elections took place during the 1964–1985 period, these were clearly less significant in nature. This implies that the political scenario initiated in the 1990s was unprecedented. Two-thirds of citizens now began to vote in elections. Thus, the incentives for politicians at this time were vastly different in nature than those of previous periods. This is particularly true and relevant for the presidency, given the strong presidentialism that prevailed after the 1988 Constitution (Fig. 6.1).

The electoral races have been particularly competitive. Out of six presidential elections that took place after the return to democracy, on only two occasions—in 1994 and 1998—was the decision taken in the first round (by

[6] Rudra and Haggard (2005), Segura-Ubiergo (2007), Rudra (2007).

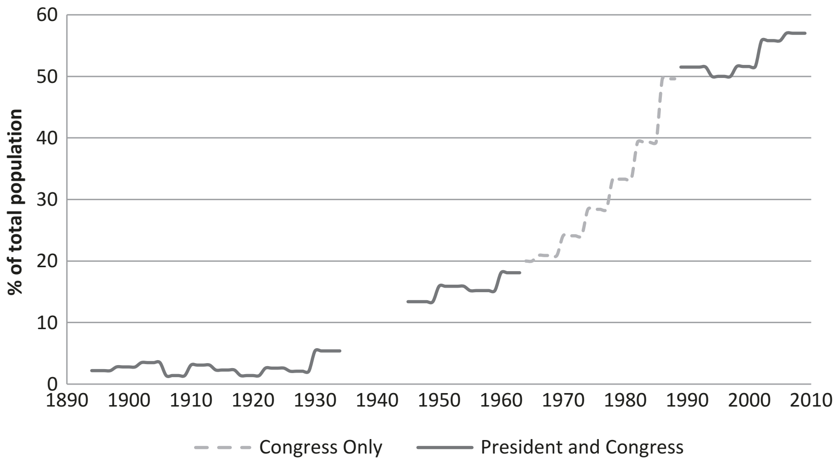

Fig. 6.1 Percent of total population that voted in presidential and congressional elections, 1894–2010
Notes: Data are for the total number of voters that actually voted and not the number eligible to vote. Data for congressional elections are for the period after 1933 and is very close, but not identical, to that for presidential elections
Source: Created from Alston et al. (2013).

margins of victory of 27 and 22 percent, respectively) and on four occasions there were competitive run-offs. The margins of victory were 12 percent in 2010, 20 percent in 2006, 19 percent in 2002 and 6 percent in 1989. More importantly, the presidential race involved two social democratic parties, the Workers' Party and the Brazilian Social Democracy Party, which in different degrees were both committed to programmes for social welfare and inclusion. During the vote in the Constituent Assembly, legislators from both parties supported universal health care and a generous social security system.

Since the early 1990s, the national political agenda has been dominated by a discourse that has emphasized the expansion of coverage in the system and the need for increased funding. In sum, the political market has been very competitive and equally important elections have been fair and transparent. Universal social security is an outcome that is consistent with theoretical expectations about competitive democratic elections in the contexts of high levels of exclusion, inequality and poverty. Because the mean income is higher than the median voters' income, it follows that strong pressure will emerge for redistribution (Melo et al. 2014). This pressure is a key point of the political viability and sustainability of universalism as a programmatic goal. Electoral

institutions with integrity and political competitiveness are crucial in assuring this outcome. If the system is competitive, then politicians converge on the need to politically serve the interests of the median voter. The medium- and long-term consequences of this convergence is that the process becomes path-dependent. A large clientele of social security beneficiaries, ranging from old age and survivors pensioners to end-users of medical facilities, makes up a formidable interest group with much political clout.

There is robust empirical evidence that electoral pressure from SUS users are correlated with the number of clinics (affiliated with the SUS), doctors and nurses per capita. All three inputs are higher in counties with a higher percentage of poor people in the population (a higher Gini coefficient, holding per capita income constant) and a higher percentage of citizens favouring redistribution (Mobarak et al. 2011; Kuhn 2012).

Another key factor explaining the sustainability of universalism is political stability. Indeed, this is as crucial as political competition in providing a stable institutional environment, in the absence of which policy reversals take place and policies and programmes are discontinued. Since 1989—the year of the first presidential election after democratization—the country has elected six presidents, impeaching one in 1993 for corruption, but has otherwise seen peaceful alternation between national leaders, with two large coalitions dominating the national political landscape.[7] The crucial test for institutional stability was indeed the victory of the Workers' Party in the presidential election of 2002. There was also significant policy continuity in macroeconomic management and social policy making despite power alternation, which suggests some deeper consensus and shared beliefs among the relevant political actors.

Creating Fiscal Capacity for Universalistic Health Spending

A crucial factor underpinning the universalization and expansion of the social security system (including health care and social assistance) is fiscal capacity, which, in the case of a new democracy with a long history of balance-of-payment problems and high inflation, essentially requires macroeconomic

[7] Since the time of writing, another presidential impeachment has taken place—that of Dilma Rousseff—amidst a large corruption scandal, political instability and a severe economic recession.

stabilization. Shortly after the promulgation of the Constitution, the country embarked on an unstable path characterized by hyperinflation and fiscal crises. Some of the constitutional provisions exacerbated existing fiscal problems.

The fiscal imbalances were monetized and paved the way for the hyperinflation experienced in the period of 1988–1993. This deterioration threatened to undermine the expected social gains from the generous social provisions introduced by the Constitution. It was only when inflation was tamed from the mid-1990s onwards that the regressive impact of hyperinflation on citizen's welfare started to be effective. This occurred under Cardoso's first administration (1995–1998), when the Real Plan was implemented. Unlike previous fiscal and monetary plans, which were associated with the so-called "shock therapy", Cardoso's plan was extensively publicized prior to its implementation. It called for the introduction of a new currency pegged to the US dollar and generated short-term gains in terms of real income for the population, which explains its popularity.

The massive expansion of the SUS required the creation of significant fiscal space and the governments in the 1990s were able to create the necessary fiscal space. Since 1990, the tax burden (central government tax revenue) as a percentage of gross domestic product (GDP) has increased from 25 to 35 percent, placing Brazil as an outlier in Latin America. Brazil's tax burden is double the Latin American average (17 percent). Controlling for Brazil's income level, the tax burden is much higher than that found in comparable countries (Melo et al. 2014). This has been accomplished by an impressive increase in indirect taxation and social contributions. It also has allowed an equally striking increase in social spending: it reached USD 1,400 per capita in 2009—the highest in Latin America, just below Argentina and Uruguay, which boast higher purchasing power parity (PPP) per capita incomes—USD 16,000 and USD 14,440, respectively, compared to Brazil's USD 11,200 (ECLAC 2009). Although the tax system has in-built inequities and inefficiencies, it has allowed fiscal sustainability and the expansion of social spending. A significant part of social expenditures is allocated to public sector pensions, but social expenditures have helped reduce poverty and allowed funding of universal health care.

The fusion of expenditures for health care and pensions in the same budget over time produced a dynamic that was paradoxically highly detrimental to health care. This resulted from the fact that pensions are contractual disbursements and are not compressible. They are a flux of

future commitments that ends only with the death of the pensioners. By contrast, health expenditures are mostly current expenditures that can, by definition, be changeable. However, prior to the Constitution of 1988, this did not become problematic since the fiscal imbalances in the pension schemes were not particularly significant and, more importantly, pensions were not indexed. This resulted gradually in the significant reduction in the real values of pensions. By mandating that pensions were to keep their real value, the Constitution of 1988 prohibited the erosion of the real value of pensions and benefits that prevailed up until 1988. In addition, it dramatically expanded the mass of workers under the civil service regime (*Regime Jurídico Único*, in which benefits are related to the average of last pay checks), upgraded rural non-contributory pensions and social benefits to the level of urban pensions, and finally set the lowest value of pensions at the minimum wage level. This produced a shock in the system and caused the crowding out of health expenditures shortly after its implementation.

The mechanism described took place while the decentralization of health care was being implemented. In the mid-1990s, while efforts towards macroeconomic stabilization were undertaken, the main policy priority became the control of inflation and the establishment of fiscal stability. However, the problems in the health sector acquired increasing saliency in the public discourse as a result of the implementation of the SUS. The recurrent crisis of the SUS enhanced the visibility of health financing in the country. At the same time, Brazil exhibited infant mortality rates that were well above countries at the same level of development. Revamping the health system along the lines of a universalistic welfare state compatible with the conditions of a developing country was also a key priority for the government. In 1996, Health Minister Adib Jatene made strong efforts to secure more resources for health care, and many proposals were made for earmarking resources for the health sector. These proposals were criticized by the finance and planning ministries as a backwards step that would cause more fiscal rigidities in a context of rapidly declining degrees of liberty in the budget. The argument that more resources were needed for the health sector was used in negotiations leading to the creation of the social emergency fund (*Fundo Social de Emergência*) in 1994. This fund would involve essentially "de-freezing" 20 percent of taxes and contributions that could then be freely allocated by the executive to allow more discretion in fiscal management. The measures to secure financing for the health sector culminated in the proposal to reformulate the

Provisional Contribution on Financial Transactions (*Contribuição Provisória sobre Movimentações Financeiras*, CPMF) and earmarking part of it to the health sector. The CPMF was created by Constitutional Amendment 3 in 1993 and was a "sunset provision" that would be valid for only two years. Constitutional Amendment 12 reinstated the CPMF and earmarked it for the health sector in 1996.

In 2000, Cardoso proposed Constitutional Amendment 29, which stipulated minimum values for investments in the health sector for the three tiers of government. For the federal government, the budget for 2000 was set at the 1999 level plus 5 percent. For the subsequent period 2001–2004, the value of health expenditures was to be readjusted by the annual variation of the nominal GDP. Of this amount, 15 percent should be transferred to the municipalities for basic health care and distributed according to their level of population. In the case of the states, 12 percent of their revenue (after legal transfers to the municipalities) was to be spent in the health sector. In turn, the municipalities were required to spend 15 percent of their own budget on health care. The states and municipalities that had expenditure levels lower than those stipulated in 2000 were expected to reduce the difference at the ratio of 1:5 per annum.

Piola et al. (2013) estimated the impact of Constitutional Amendment 29 as very positive, leading to a jump in the amount of resources allocated to health that was equivalent to 1 percent of GDP. It rose subsequently from 2.9 percent in 2000 to 3.9 percent in 2011. Mounting pressure to find more resources for health care led to the discussion of new legislation, which has not yet been approved. Because the amendment left many loopholes regarding the categories of expenditures that could be classified as falling under the bracket of health expenditures, the government passed the Complimentary Law 141/2012. The CPMF's share in the total amount of resources in the area of health was significant, reaching 32 percent in 2007 when it was phased out.

Originally designed to be a temporary tax with a rate of 0.38 percent on financial transactions earmarked to the SUS, the CPMF lasted as a provisional contribution for about 12 years. It was finally extinguished on 13 December 2007 in a historical roll call when the executive's bill requesting its extension until 2011 was defeated in the Senate.

This episode represents a signal and a remarkable mobilization of several different sectors in society (media, interest groups, business sectors, etc.) and of opposition players demonstrating that the leverage of the federal

government to keep increasing the tax burden was running out. One of the most important criticisms of the CPMF from those sectors was the lack of transparency in its allocation. In fact, the CPMF was never fully allocated to the universal health care system as it was originally intended; rather, it was diverted to other ends, for example, for raising the budget surplus. The resistance against the CPMF from the Federation of Industries of the State of São Paulo (*Federação das Indústrias do Estado de São Paulo*, FIESP), which was composed of more than 200 unions and associations, was able to gather more than 1.5 million signatures from all over the country against the CPMF and at the same time supporting the idea of a comprehensive fiscal reform. This movement has acted as a watchdog against any further government's attempts to bring the CPMF back in and to mobilize the society in opposition to additional tax increases.

These two initiatives to secure more resources for health—Constitutional Amendments 12 (CPMF) and 29 (earmarking budgets for health expenditure in the total budget)—were key to securing more resources for the sector. However, the system has become more expensive and complex, resulting in a considerable level of financial stress. Despite the considerable absolute increase in resources, the share of resources devoted to health has stagnated, engendering great tension. The share in 2002 was the same as in 2012. This partially reflected the fact that the spectacular expansion of conditional cash transfers has had a crowding-out effect on health. Costing slightly more than 1 percent of GDP, the *Bolsa Família* and smaller transfer programmes have absorbed part of the additional resources to universal social security as they share the same source of funding. *Bolsa Família* has become the flagship programme of the Workers' Party's governments (2003 to 2016), and has certainly dwarfed the political saliency of other issue areas for the government agenda (Melo 2007a, b).

The episode involving the extinction of CPMF points to the fact that the tax burden has reached a plateau. At 35 percent of GDP, it is slightly lower than the Organisation for Economic Co-operation and Development (OECD) average. More importantly, the political feasibility of raising additional taxes in Brazil has declined rapidly. Considering that coverage of the SUS has also reached a plateau of 100 million people, this means that quality improvements in the SUS would have to be achieved through efficiency gains rather than by funnelling more resources into the system (although that might be necessary in many municipalities across

the country as well). However, since 2012, and particularly following a wave of street protests in 2013, there has been strong social mobilization for more resources for health care.

State and Organizational Capacity for Universal Social Security

In addition to fiscal capacity, an effective welfare regime requires state capacity. In fact, the latter is also a precondition for fiscal capacity: extracting resources from corporations and families is a complex task and in a democracy it requires the presence of a capable state machinery. The sophisticated social security system Brazil has built over the last two decades was made possible because the country had already created an effective bureaucracy prior to its massive expansion. However, concomitantly with the expansion of this system there has also been an extensive overhauling of the country's social ministries.

Prior to the 1990s, the ministers in charge of the social ministries were typically clientelistic politicians. In sharp contrast, from the mid-1990s onwards the ministers of social security and health have been economists or health policy experts. More significantly, a number of careers have been created within the federal government, including experts in public policy and public management and social policy analysts. Over a thousand new experts have been hired on a meritocratic basis for key posts in the line ministries, two-thirds of them being, at the time of writing, staff in the social ministries. According to the Inter-American Development Bank, by the mid-2000s, Brazil boasted the most professionalized bureaucracy in Latin America (Longo 2006). Another crucial development within the social ministries was the strengthening of external control and internal audits. In the past, the ministries of health and social assistance along with education were the organizations where corruption tended to concentrate.

Following the strengthening of the Audit Tribunal to the Union in the 1988 Constitution and the creation of the Secretariat of the Federal Comptroller, both external and internal audits have improved considerably, leading to the professionalization of these ministries and the creation of a modern new Ministry for Social Development in 2003. In the wake of the creation of the SUS, the decentralization of health in Brazil

involved transferring 1 percent of GDP to subnational governments in a scale unparalleled in Latin America (Leite 2010). Massive decentralization of funds is associated with high risks of agency losses, making it necessary to put oversight mechanisms in place. In 2002, the Cardoso government transformed the existing *Secretaria Federal de Controle*—the internal audit body in charge of monitoring public expenditures and making sure that financial rules were followed in the public sector—into the *Controladoria Geral da União* (CGU). This measure was complementary to the enactment of the Fiscal Responsibility Law 2000, which imposed a host of requirements for transparency, monitoring and reporting for subnational governments in Brazil. With a mandate to fight corruption and ensure compliance with transparency and administrative procedures, the CGU has improved the professionalization of state machinery in the social sectors. Using data from randomized municipal audits, it was found that 27.8 percent of municipalities had serious irregularities in the use of health funds (Melo et al. 2012; Leite 2010), whereas the corresponding figure for education was 25.1 percent, despite the fact that the value of funds for health is significantly greater than in education. Local corruption in health services is rampant, but there is evidence that CGU audits have had an important deterrent effect.

Political and Institutional Challenges to Universal Health Care

Although the SUS continues to receive strong support as a political priority, there is widespread dissatisfaction with the quality of the services it provides. This is also found in other areas, including educational services. Subjective evaluation of the quality of public expenditures is very low: 15 percent of respondents in Brazil replied positively when asked in 2012 about their trust in the quality of spending—a figure that was well below the Latin American average.

The level of satisfaction with public services has reached very low levels—in fact, the lowest score in the sample of countries in the available Latin America Barometer, the Latin American Public Opinion Project

(LAPOP) data sets.[8] Only 40 percent of respondents were satisfied with public services. A LAPOP survey carried out in 2012 found that 72.8 percent of the population was either unsatisfied or very dissatisfied with medical and public health services in 2012. In turn, a study by the National Confederation of Industry found that 61 percent of the population considered public health services to be either bad or very bad and that 85 percent of respondents saw no change or worsening services over the previous three years (CNI 2012: 9). The problems that are most commonly reported are delays in access or treatment and lack of doctors. The main criticism raised against public hospitals, which were rated worse than private hospitals, were waiting times for consultations and exams.

Interestingly, in the LAPOP 2012 survey, Brazilians and Chileans—citizens of the two countries with the most successful economies in the region—were the least satisfied with the quality of public services of all citizens in Latin America and the Caribbean. The economic progress of recent years and the emergence of a new middle class have raised expectations, and many Brazilians and Chileans say they also want to see social progress. Concerns with service quality in Brazil came rapidly to the fore for contextual reasons. People protested against the government's decision to overspend on the construction of new and/or renovating old soccer stadiums for the 2014 FIFA World Cup. Criticisms that the final cost would significantly exceed the initial budgets, coupled with public perceptions that little had been done to improve urban infrastructure triggered protests across the country. Reacting against the "FIFA-Standard Soccer Stadiums", demonstrators carried signs in the streets asking for "FIFA-Standard Hospitals". Even before the July 2013 events, there was mounting social mobilization to increase resources for health and a new movement was created, the *Movimento Nacional Em Defesa da Saúde Pública*, with the motto *Saúde + 10*.[9] Thus, the saliency of health care for the current agenda may be a window of opportunity for policy change. As Carnes and Mares (2012) have argued, dissatisfaction and perceived increasing risks have led citizens in Latin American to support the health

[8] Latin American Public Opinion Project (LAPOP) 2012 data. Accessed 13 February 2014. www.vanderbilt.edu/lapop.

[9] *Saúde + 10* is a proposal for health expenditure to be earmarked at 10 percent of current federal expenditure.

care policy reforms towards universal care. Recent developments in Brazil suggest that the reversal of expectations in the wake of the commodity boom increases the demand for improvements in health care coverage.

Conclusion

Over the last two decades, Brazil has built a relatively successful universal health system. Its success was made possible by the combination of three factors. First, political incentives arising from electoral competition in a competitive institutional environment resulted in a race to serve poor constituencies, which were introduced by policy communities and activists both within and outside the state. The SUS benefited from this political dynamic and thus became politically sustainable. Second, the SUS's fiscal sustainability, which was secured by the great extractive capacity of the Brazilian state, was the product of a massive increase in resources in the form of social contributions partly earmarked for pensions, social assistance and health care. Third, part of the system's success stems from the institutional capacity to run a complex decentralized system. The system's enormous expansion and great coverage has led to a plateau—over 100 million people are now benefiting from the system.

The system appears to reach its limit in terms of the capacity to extend coverage in a context where there is universal formal entitlement to health, but some 30 percent of the population has access to private insurance. Coupled with the costly judicialization of access to health care and pharmaceutical drugs, which disproportionally benefits the richer groups, the SUS has engendered a perverse incentive structure that is built into the system, leading to great inequities across society. Despite significant improvements, many challenges continue to beset the delivery of health care in Brazil, and addressing them adequately will require significant policy changes, not only additional resources. However, finding resources has proven increasingly costly politically and improvements will have to be achieved through efficiency gains. Politically, this is a situation of a zero-sum game rather than that of the positive game typical of coverage expansion. Most importantly, the perceived increased personal risks are leading citizens to support the creation of new resources for the system, and for policies to improve the quality of health care. A new window of opportunity thus seems to have been opened.

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7

Universalizing Health Care in Brazil: Opportunities and Challenges

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Introduction

Brazil is one of the world's largest economies—a country with a recently recovered, yet stable democracy based on relatively solid political institutions. Despite difficulties related to the global economic crisis, Brazil enjoys a privileged position in the region, enabling it to shape a new developmental model that integrates economic and social policies with a strong emphasis on universalism. Known as "new developmentalism",[1] this model puts forward a national development strategy aiming not only at economic development but also at social inclusion through the strategic role played by the state in advancing development and reducing

[1] In 2010 a group of prominent Brazilian and international scholars debated and approved a manifesto entitled *Ten Theses on New Developmentalism*. Accessed 7 March 2016. http://www.tenthesesonnewdevelopmentalism.org/.

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inequalities (Sicsú et al. 2007; Bauman 2011), especially in terms of income and access to services, the priority assigned to development and the emphasis placed on the social and environmental setting (Bresser-Pereira 2012a, b).

The policy regime associated with the model of "new developmentalism" in Brazil is characterized as hybrid in the sense that it combines both neoliberal policies (for example, a policy priority of macroeconomic stability, privatization, liberalization and deregulation reforms, conditional cash transfers, etc.) and more interventionist ones associated with neo-developmentalist thinking. These latter policies include a reduced reliance on foreign savings; an "off-the-books" stimulus package during crises; the state as owner and investor in industry and banking; increases in the minimum wage; industrial policies targeted at high employment sectors and the use of state-owned firms to expand welfare and employment (Ban 2013).

Evidence suggests that the macroeconomic and social performance of this hybrid policy regime has been positive. A recent study (IPEA 2012a) reports the following changes during the period 2001–2011: an increase of 32.4 percent in average household incomes per capita, a 55 percent reduction in the population with household incomes below the poverty line and a reduction in inequality, measured by the Gini coefficient, from 0.594 to 0.527. According to the study, this decrease in inequality is explained by the increase in real labour income (58 percent), social security benefits (19 percent), conditional cash transfer programmes such as *Bolsa Família* and *Brasil Sem Miseria* (13 percent), social assistance benefits to the elderly (4 percent) and other income (6 percent). During this period, there was also great expansion of the formal labour market, with continuing reduction in the degree of informality, which decreased from 55.1 percent in 2001 to 45.4 percent in 2011 (IPEA 2012b).

One of the social policy sectors that has made notable progress is the health sector. A review of health policy development over the last two decades shows that the Brazilian health care system has made significant progress towards universal health coverage (see Table 7.1). The capacity of the system to provide health facilities and care networks for outpatients has significantly expanded, while regional disparities in access to health services have been reduced; access to primary health care has also

Table 7.1 Selected health care coverage indicators in Brazil, 1998–2012

	1998	2003	2008	2012
Population covered by Family Health Teams (percent)	3.1	35.7	49.5	54.5
Medical consultations (per habitant)	2.28	2.42	2.59	2.77
Population that had a medical consultation in the last 12 months (percent)	54.7	62.8	67.7	71.2 (2013)
Population that had dental consultation in less than 1 year (percent)	33.2	38.8	40.2	44.4 (2013)
Women of 50–69 years that never had a mammography test (percent)		45.3	28.9	
Live births with seven or more prenatal care consultations (percent)	49.4	51.1	57.7	61.8 (2011)
Hospital admissions in the public system (per 100 habitants)	7.2	6.5	5.6	5.6

Source: Data from DATASUS (2012) and IBGE (2015), compiled by the authors

significantly expanded, while health outcomes such as life expectancy and infant mortality have been considerably reduced (Paim et al. 2011; Barreto et al. 2014). Although many challenges and limitations remain, such as gaps in primary care coverage and barriers to accessing specialist and high-complexity care, Brazil has significantly developed its health system and become a "stellar performer, with nearly universal coverage and limited geographic disparities" in the areas of "immunizations, antenatal care, and hospital deliveries" (Gragnolati et al. 2013: 6).

Universality and equality of health services were not constitutional rights in Brazil until 1988 when the new constitution stated that health is a right of all and a duty of the state, and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at universal and equal access to procedures and services for health promotion, protection and recovery (Brazil 2013a). In that year, the Constitution formally established the Brazilian Unified Health System (*Sistema Único de Saúde*, SUS), based on three overarching principles: universal access to health services with health defined as a citizen's right and an obligation of the state, equality of access to health care, and integrality (comprehensiveness) and continuity of care.

Before the creation of the SUS, the regular source of health care in Brazil was the social security system, whose origins dated from the 1920s when some companies created the first *Caixas de Aposentadorias e Pensões*

(CAPs) to offer retirement benefits, pensions and health care to their employees. The CAPs were progressively replaced by the *Institutos de Aposentadorias e Pensões* (IAPs), classified according to professional categories (for example, government employees, railway, banking, commerce, etc.) and funded by employers, employees and the government. With the foundation of the National Institute of Social Security (*Instituto Nacional de Previdência Social*) in 1966, all existing CAPs and IAPs were merged in that organization, managed by the federal government. In 1981, this system offered health care services to 49 percent of the Brazilian population, while public and free philanthropic services such as hospitals linked to the Catholic Church offered services to 19 percent of the population, and private health insurance covered another 10 percent (see Table 7.2). The remaining 22 percent were not covered and had to make out-of-pocket payments to access services provided by private health care providers. The creation of the SUS expanded the coverage by integrating elements of the previous system throughout the country and improving access to primary health care, especially through the family health strategy, which is currently implemented in 98 percent of municipalities. In 2015, about 70 percent of Brazilians had access to primary care provided by the SUS, while a greater proportion of the population, including those already covered by private health insurance (26 percent in 2015) also had free access to expensive services such as hospitalization and high-cost therapies.

In terms of financial protection, available data show that the share of total household spending dedicated to health increased from 5.3 percent in 1988/89 to 7.2 percent in 2008/09. This result is explained by the expansion of spending on private plans and drugs over the period. These amounted to some 76 percent of private health expenditure in 2008/09, while service charges such as consultations, hospitalizations and dental care became relatively less important, declining from 50 percent of out-of-pocket spending in 1987/88 to just 20 percent in 2008/09 (Gragnolati et al. 2013). Furthermore, estimates for catastrophic health expenditure (Boing et al. 2014) show that a small proportion of households incurred this type of spending in 2008/09, ranging from 1.4 percent (when calculated as a proportion of households that spent 20 percent or more of their total consumption) to 5.8 percent (when calculated as a proportion

Table 7.2 Selected indicators related to coverage, finance protection and quality of health care in Brazil, before and after SUS

		Before SUS (1981)	After SUS (2015)
Coverage	Social security	49 %	Not applicable
	Public services	5 %	Not applicable
	Free philanthropic services	14 %	Not applicable
	SUS[a]	Not applicable	69.7 %
	Private health insurance	10 %	25.9 %
	Total covered	78 %	95.6 %
Financial protection	Household budget spent in health	5.3 % (1988/89)	7.2 % (2008/09)
	Catastrophic health expenditure[b]	Not available	1.4 %–5.8 % (2008/09)
Quality	SUS performance index (IDSUS)[c]	Not applicable	5.47 (2010)
	Supplementary health care performance index (IDSS)[d]	Not available	0.8–1.0: 31.5 % 0.6–0.79: 44.4 % 0.4–0.59: 14.7 % 0.2–0.39: 5.2 % 0–0.19: 4.2 %

Source: Pre-SUS coverage from Gragnolati et al. (2013); After SUS coverage from the Brazilian Ministry of Health (DAB/SAS/MS) and the National Regulatory Agency for Health Insurance and Plans (ANS); Household spending on health from the Consumer Expenditure Surveys by the Brazilian Institute of Geography and Statistics (IBGE); Catastrophic health expenditure retrieved from Boing et al. (2014); IDSUS from the Brazilian Ministry of Health

[a]Refers only to primary health care coverage provided by the SUS

[b]Proportion of households that spent 20 percent or more of their total consumption with catastrophic health expenditures and 40 percent or more in relation to their capacity to pay

[c]The SUS Performance Index (IDSUS) was designed by the Brazilian Ministry of Health in 2011 to measure the performance of the SUS at local, state and country levels. This index ranges from 0 to 10, and is composed of 24 indicators, 14 that measure access to health care and 10 that measure the effectiveness of the system

[d]The supplementary health care performance index (IDSS) was designed by the National Regulatory Agency for Health Insurance and Plans to measure the performance of each company that operates health insurance and plans in Brazil. This index ranges from 0 to 1 and is calculated through a set of indicators clustered into four dimensions: health care, economic and financial aspects, structure and operations, and user satisfaction

of households that spent 40 percent or more in relation to their capacity to pay). Brazil also compares favourably with other Latin American countries, presenting lower levels of catastrophic spending (Knaul et al. 2011). However, it should be noted that it is significantly higher among

poorer households and households with children and older adults,[2] which suggests inequality on private health care spending.

Quality indicators to measure the performance of both public (SUS) and private (insurance and plans) health care systems suggest that there is considerable room for improvement. The overall score for the SUS performance index (*Índice de Desempenho do SUS*, IDSUS), an indicator that seeks to measure access to and effectiveness of the public system, is 5.47 (out of 10), with great variations among macro regions, states and municipalities (Brazil 2012). With regards to the private health insurance and plans, the supplementary health care performance index (*Índice de Desempenho da Saúde Suplementar,* IDSS) shows a more positive scenario, as 75.9 percent of the companies obtained more than 0.6 points.[3] Together, those companies offer coverage to about 89 percent of the clientele.

How did Brazilian society make such significant progress in terms of economic and social development and take such important steps towards universal health coverage? What are the institutions and actors that have driven the universalization of health care within Brazil's hybrid policy regime, particularly given the fact that one of its main pillars is neoliberalism, often regarded as the single most important variable in explaining the reduced role of the state and welfare retrenchment?

The Institutional Context of Universalization

Brazil is a federative country, whose political structure includes three levels of government with the same level of political and administrative autonomy: one federal government, 26 states, one federal district and 5570 municipalities. Article 198 of the Brazilian Constitution calls for a Unified Health System based on a regionalized and decentralized network of health services with coordinated management at each level of government, community participation and the prioritization of prevention as part of an integrated approach to health services delivery. Subsequent

[2] Boing et al. (2014), Barros et al. (2011), Knaul et al. (2011).

[3] However, the fact that the health care insurance and plans industry in Brazil presents a high level of customer complaints, especially concerning coverage among the elderly (Vieira Junior and Martins 2015), is an indication that patients find barriers to accessing appropriate services.

legislation attempted to define the role of each level of government in health care management and provision.

Article 199 of the Constitution is also notable in that it defines the participation of the private sector in the SUS. Accordingly, the private practice of medicine and medical institutions were allowed to play a complementary role in the SUS (Elias and Cohn 2003). Thus, universal health coverage guaranteed in the Constitution has been implemented by two major systems of health care: public health services dependent upon resources from the budget of each level of government (but carried out by both public and private sectors regulated by the government), and individual medical care for urban workers, funded by monthly fees for voluntary-based health care plans, insurance premiums and out-of-pocket payments.

In terms of provision of services, the public system comprises Brazil's largest network of primary health care providers, especially in the poorest regions such as the Northeast. The majority of hospitals and medical clinics are, however, private and located in the most developed regions. In terms of its financial structure, Brazil has a similar structure of public–private provision to those of many developing countries in which health care is predominantly financed from private sources. Most hospitals in Brazil are privately owned and the majority of their revenues come from voluntary, pre-paid health care plans and out-of-pocket payments. There is also a large network of non-profit hospitals that provide health care services to the public system.

Thus, the health system in Brazil is a mixed system—both public and private, with segmentation of customers (those who can afford private care and those who cannot) and a variety of relationships between providers and customers. Indeed, a significant number of hospitals and physicians have a direct relationship of buying and selling services through both the public and private health sectors. At the same time, public health facilities continue to deliver care to patients with private insurance, especially for procedures that are too expensive or not covered by private health care plans, such as medicines for AIDS treatment, haemodialysis and surgical transplants. In this context, implementation of the SUS has been complicated by the concentration of health services in the more developed regions of the country, as well as chronic underfunding and state support for the private sector.

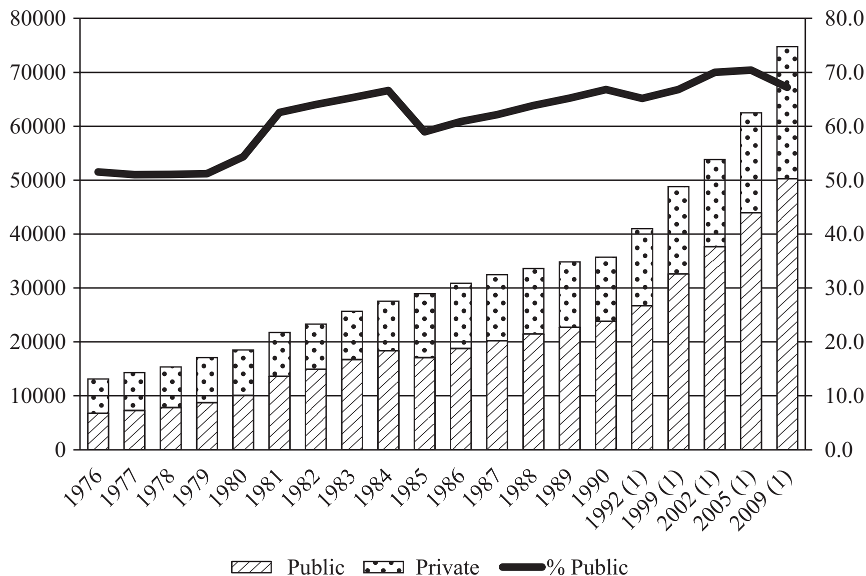

Fig. 7.1 Total public and private health facilities in Brazil, 1976–2009. *Note*: (1) Excluding facilities that provide support services only (*Source*: Data from IBGE (2010), compiled by the authors)

Despite these limitations, the SUS has managed to vastly improve access to primary and emergency care by expanding health facilities (see Fig. 7.1). It has reached universal coverage in vaccination and prenatal care, improved access to drugs for both inpatients and outpatients, and made investments in the expansion and qualification of human resources in the SUS, with specific policies aimed to attract and train health professionals,[4] and to enhance technology, including major efforts to meet the country's most essential pharmaceutical needs (Paim et al. 2011).

Those institutions and actors driving universalization of health care are especially visible in the following dimensions of health system development: (i) regionalization and expansion of the public health care system;

[4] Such as The Nursing Staff Professional Training Project (Profae) which employed 13,200 nurses to train 230,000 auxiliary nurses; The SUS Open University (UNA-SUS) which comprises public universities, state health secretariats, and telemedicine units; and the More Physicians Programme (*Mais Médicos*) which attracts international medical graduates to work in primary care units in more remote areas of the country.

(ii) stable and sufficient funding to ensure the principle of universality within the SUS; and (iii) regulation of health science, technology and innovation procedures and public-private relations. The interactions between neoliberal and interventionist policies, which constitute the institutional and political arrangements in these dimensions, also create policy challenges for the health system, which need to be resolved urgently (Cohn 2008).

Regionalization and Expansion of the Public Health Care System

When the democratization process began in the 1980s, the issue of decentralization became central to the democracy debate among Brazil's democratic players. This was due to the strong reaction of anti-authoritarian movements against centralized government on the one hand, and the relative strength of some states vis-à-vis the nascent democratic federal government (which was facing severe fiscal challenges) on the other (Pierce 2013). The transfer of resources, competencies and responsibilities to subnational levels of government was seen as the antithesis of military rule and authoritarianism and as a result of the demand for broader democracy and greater governmental efficiency (Ribeiro 2009; Viana 2014). Actors from the public health movement, which began in the 1970s, dominated the constitutional legislation process in health-related areas, and Article 198 of the 1988 Constitution described decentralization as one of three major principles underpinning the health system, together with unified care with a focus on prevention and the participation of civil society in health policy deliberation (Avritzer 2009).

Despite an overall consensus on the necessity of decentralization, however, significant differences in the means of decentralizing power existed within and between progressive and conservative political forces,[5] in

[5] It is difficult to identify which political parties belonged to democratic or conservative political forces in Brazil in the 1990s, since the country was one of the most fragmented in the world. The ideological map of political parties in Brazil is not clear, and the differences between parties are constantly shrinking as the parties move towards the centre of the political spectrum. See Power and Zucco (2009), Lucas and Samuels (2010), Samuels and Zucco (2013).

particular with regard to health policy. In addition, the process of decentralization was not accompanied by other economic and social interventions driving national development (Gadelha et al. 2009). On the contrary, the developmentalist agenda was replaced by the debate on the re-democratization of the country in the 1980s and the pursuit of monetary stabilization in the 1990s (Sallum 2004).

Neoliberal agenda items such as downsizing the state and achieving macroeconomic stability became prominent in the policy discourse in the context of structural adjustment policies promulgated by international financial institutions such as the International Monetary Fund (Elias and Cohn 2003; Sallum 2004). The health budget of the federal government was also significantly reduced, in particular during the late Sarney and Collor governments between 1989 and 1992 when the federal share of governmental health spending dropped from 77.7 percent of the total budget in the 1980s to 53.7 percent in 1996 (Elias and Cohn 2003). As a result, the decentralization of the health system was designed and implemented in line with this broadly neoliberal policy framework.[6]

In this policy context, those who had led anti-authoritarian movements in the 1970s and 1980s pushed for the establishment of participatory regulating mechanisms such as national health conferences and health councils. The Organic Health Law of 1990[7] legally mandated health conferences and health councils to play the role of permanent deliberative institutions composed of representatives of the state, service providers and representatives of the population, as well as participating in the elaboration of strategies and the implementation of health policies at each level of government.

The resulting plan for the implementation of the SUS was different from the original design of public health system reform. Elements such as technical support and the provision of stable and regular funding—which would achieve the objectives of the national health policy (that is, guaranteed universal access to health programmes and services and

[6] Melo (1996), Costa (2002), Noronha and Soares (2001).

[7] Law 8080, of 19 September 1990, provides information about conditions for the promotion, protection and recovery of health, the organization and functioning of the corresponding services and other provisions. Law 8142, of 28 December 1990, provides on community participation in the management of the SUS and on intergovernmental transfers of financial resources in health.

comprehensive care consistent with the needs and demands of the public)—were not included. Consequently, the results of the decentralization of the Brazilian health care system became highly dependent on existing local conditions (Viana et al. 2003). In other words, the characteristics of the decentralized health systems are highly heterogeneous nationwide, reflecting different financial, administrative and operational capabilities for health care provision and the different political arrangements of governors and mayors (Souza 2002).

The narrow understanding of the federative design of the country in the 1988 Constitution is another factor that shaped the nature of decentralization. National governments during the 1980s and 1990s disregarded the role of state-level governments and emphasized the responsibilities of municipalities in the provision of services, a process often dubbed "municipalization". As a result, municipalities with populations ranging from a few thousand to several million assumed considerable autonomy in terms of organizing and managing the health system and health resources.

Hence, decentralization over the first decade of SUS implementation was based on the practice of direct relations between the federal and municipal spheres that had been adopted since the beginning of the process (Levcovitz et al. 2001). Although the Brazilian Constitution approved political institutions that combine broad jurisdictional authority for the federal government along with limited institutional veto powers for subnational governments (Almeida 2007; Arretche 2009), the 1990s witnessed a transition from a centralized system to a model in which thousands of local governments acquired greater autonomy, assuming an important role in the area of health.

Nevertheless, the problems of the intense fragmentation and disorganization of health services remained, with thousands of isolated local systems (Viana et al. 2010). The fragility of the relations between states and municipalities made it difficult to organize regional, hierarchical health networks to ensure that the population had access to all levels of care (stipulated in the 1988 Constitution). Indeed, regional-based integrated health care networks were not actively promoted in this process (Dourado and Elias 2011; Vargas et al. 2014).

The establishment of heath regions—contiguous geographic areas consisting of clusters of neighbouring municipalities, delimited by cultural,

economic and social identities and by shared communications and infrastructure designed to integrate the organization, planning and execution of health care services—only became the focus of national health policy in the 2000s. The definition of a "health region" appeared for the first time in *Health Care Operational Regulations*, published in 2001, the main objective being a fair allocation of funds and access to health care services.[8] Regionalization was then defined as a macro strategy to enhance decentralization, based on a framework of integrated planning.

One of the major institutional conditions of regionalization was the enhanced role and functioning of state-level governments. Drawing on the experience of implementing structural adjustment programs over the previous ten years, most Brazilian states were able to enhance their administrative capacity to manage public finances in an efficient and responsible manner. Thanks to the 1998 fiscal adjustment program to restructure the debts of some state governments, the public finances of most state governments were in relatively better shape than before (Piancastelli and Boueri 2008).

The Lula government (2003–2010) promoted a system of management and decision making for health regions based on cooperation, solidarity and consensus by establishing the Pact for Health in 2006.[9] The pact reaffirms regionalization as a basic part of the health system and promotes it as "the guiding framework of the Administrative Pact" which orientated both the decentralization process and intergovernmental relations. It intended to increase the scale of health procedures and services with regional scope by establishing health regions that would be delineated through understandings between states and municipal managers, as legitimized in Bipartite Inter-management Committees, on which were represented municipal and state secretaries, and Tripartite Inter-managers Committees, on which federal representatives also sat (Dourado and Elias 2011).

To operationalize the planning and management of the health regions, the Pact for Health established Regional Management Boards in each region (Brazil 2009). The boards are constituted of representatives of

[8] *Ministerial Directive GM/MS 95*, 26 January 2001. Approves the Health Care Operational Regulations (NOAS-SUS 01/2001).

[9] *Ministerial Directive GM/MS 399*, 22 February 2006. Promotes the Pact for Health 2006—Consolidation of the SUS and approves the Operational Directives of the Pact.

state health departments (from the central level or from regional state structures) and the municipal health secretariats of each region. These boards have become a permanent channel for intergovernmental negotiation and decision making at the regional level. However, the implementation of this policy is far from being optimal and effective, especially because its success depends on hard negotiation and allocation of complex responsibilities to a level of government—municipalities—too small to assume them (Vargas et al. 2014).

The Rousseff government (2011–2016) revised the idea of health care networks to address the problem of the lack of coordination across different levels of health care by establishing new guidelines.[10] These networks include services and facilities for primary care, urgent and emergency care and psychosocial care. Some policy mechanisms were designed to support the functions of the networks, including the mapping of all public and private services in the regions (the Health Map) and the Organizational Public Action Contract, whose main objective is to ensure comprehensive care for users by organizing and integrating actions and services inside health regions.[11]

The four key elements that constitute the regulatory mechanisms of these management processes have been summarized in Table 7.3: (i) mechanisms of federal funding (used for the transfer of federal funds to states and municipalities); (ii) health care models (the organization and delivery of health care); (iii) systemic rationale (integrating procedures and services within the national territory); and (iv) federal agreements and relations (relationships and the division of roles and responsibilities between the state and regional governments).

From the perspective of the current phase of construction and consolidation of the SUS, the advancement of the regionalization of health in Brazil has brought challenges for managers and leaders by:

[10] Decree 7508, of 28 June 2011. Regulates Law 8080 of 19 September 1990 that calls for the organization of the Unified Health System (SUS) to provide health planning, inter-federative relations, health care and other services.

[11] The contract must be signed by the Brazilian Ministry of Health (at the federal level), the Governor and Secretary of State for Health (at the state level), and the Mayor and Municipal Secretary of Health (at city level). As of October 2014, only two states (out of 26) had signed the Organizational Public Action Contract together with their municipalities and the Federal Government.

Table 7.3 The process of regulating decentralization and regionalization in the SUS, Brazil, 1990–2013

Period	Federal funding mechanisms	Health care model	Systemic rationale	Federative relations and agreements
1990–1992	Fee for service (predominant form)	Absent	Absent	Negotiations at the national level
1993–1995	Fee for service (predominant form) Block grants in amounts defined by financial limits	Definition of responsibility for some programmatic and health surveillance actions for more advanced, effective management at local level	Weak: tied to isolated municipal negotiations	Negotiations at the national and state levels Formalization of intergovernmental agreements
1996–2000	Fee for service Project grants by level of health care, type of service and programs (predominant form)	Health Community Agents Program and Family Health Program Priority programmes and projects for disease and health problem control	Moderate: tied to inter-municipal negotiations, with participation and mediation by states	Negotiations on national and state levels as well as isolated regional experiences in negotiations Isolated consortia initiatives Formalization of intergovernmental agreements

2001–2005	Fee for service Project grants by level of health care and type of service and programs, including the definition of inter-municipal references (predominant form)	Maintenance of previous programs and: Definition of minimum responsibilities and contents for primary health care Redefined procedures for medium- and high-complexity care Creation of clinical protocols	Strong: tied to the definitions of a set of procedures and services to be included in regional planning; emphasis on inter-municipal negotiations in the planning process under the coordination of state powers	Negotiations on national and state levels and isolated regional experiences in negotiations Isolated inter-municipal consortia initiatives Formalization of intergovernmental agreements Implementation of results assessment mechanisms for primary health care programs
2006–2010	Large block grants according to level of health care, type of service, programs and functions (predominant form)	Definition of responsibilities at all levels and fields of care	Strong: tied to the broadened concept of state-level regionalization of health; emphasis on political agreement between the different spheres of government; maintenance of instruments established in the previous period	Negotiations at national, state and regional levels Formalization of agreements between managers within National Health Pacts Implementation of mechanisms for monitoring and evaluating agreed commitments (set of target-related indicators)

(*continued*)

Table 7.3 (continued)

Period	Federal funding mechanisms	Health care model	Systemic rationale	Federative relations and agreements
Since 2011	Large block grants according to level of health care, type of service, programs and functions (predominant form) Definition of financial commitments of each federative body in the regions	Definition of responsibilities at all levels and fields of care Induced formation of specific health care networks to strengthen health research, translate knowledge and deliver integrated health care services to the population.	Strong: tied to defined minimum procedures and services in each region, the health care network and lists of actions, services and medications; emphasis on formalized commitments among the different spheres of government at the regional level; emphasis on bottom-to-top planning and the creation of new support tools for regionalization	Negotiations at national, state and regional levels Formalization of agreements among managers at all levels Mechanisms for monitoring, performance evaluation and auditing defined in contract

Source: Based on data from Viana et al. (2002)

1. Introducing organizational innovations into SUS management that support an integrated vision of the territory and strengthen regional planning of the health system;
2. Formulating specific proposals to support the regionalization of the SUS in the Brazilian states, taking into account the distinct conditions and stages of implementation of each state;
3. Emphasizing, updating and diversifying mechanisms of intergovernmental negotiation and agreement; and
4. Developing mechanisms for the intergovernmental transfer of financial resources and incentives for the implementation of policies related to regional care networks.

Secure and Sufficient Funding to Uphold the Principle of Universality

According to the Brazilian Constitution, health is one of the three constituent areas of social welfare, the other two being social security (retirement benefits and pensions) and welfare assistance. Article 195 of the Constitution establishes that these areas must be financed, directly and indirectly, by the whole of society. Funds were to come from the budgets of all levels of government (federal, states, the federal district and municipalities) and a set of welfare contributions levied on payrolls and other labour revenues, sales and corporate profits, proceeds of lotteries and, since 2003, import taxes as well.

In the early 1990s, two events aggravated the funding problems of public health services and procedures in Brazil. First, the main social contribution in terms of total proceeds—payroll taxes—was earmarked for social security, reducing the proportion of the welfare budget available for other areas, including health. Second, the establishment of the Emergency Social Fund (now called the DRU—Detachment of Federal Revenues) in 1994 allowed the federal government to direct up to 20 percent of taxes and contribution revenues to ensure the country's economic stability and the financial reorganization of the federal exchequer, thus further reducing the resources available for investments in health.[12]

[12] Estimates show that approximately USD 200 billion were subtracted from the Social Welfare budget in the period 2005–2013 (ANFIP 2014).

In 1996 a social contribution (the Provisional Contribution on Financial Transactions, *Contribuição Provisória sobre Movimentação Financeira*, CPMF), designed to be spent only on health care in order to end the chronic underfunding of the sector, was introduced. However, at no time were all the collected funds allocated exclusively to health. This was because the original Emergency Social Fund allowed that a part of CPMF funds be used by the federal government for other expenses, especially interest payments on the national debt. Additionally, beginning in 1999 the fund was used to finance other welfare and social assistance programmes and was dissolved in 2007.

A turning point for the funding of the Unified Health System was the introduction of a set of rules by Constitutional Amendment 29 (EC29), approved in 2000. It established minimum limits for the funds to be allocated by the three spheres of government to finance public health services and procedures, as follows:

- For the federal government: the amount allocated to health care in the previous year, corrected by the variation in nominal gross domestic product (GDP);
- For the states and the federal district: 12 percent of the proceeds from tax collection and constitutional transfers from the federal government, the amount of which depends upon the size of the population of each administrative unit; and
- For the municipalities: 15 percent of the proceeds from tax collection and constitutional transfers, the amount of which depends upon the size of the population of each administrative unit.

This amendment was, in fact, a mechanism to reduce the negative impacts on the health sector of a newly established macroeconomic management regime emphasizing fiscal austerity, put in place after the currency crisis of 1999, which targeted the fiscal surplus as a ratio of GDP (on average, 3 percent) (Araujo et al. 2012). The series of laws aimed at fiscal consolidation has proven to be effective in helping the government to secure and expand fiscal space, in particular when the country's economic growth started up again, beginning in the early 2000s.

These new rules for public health funding resulted in increased resources for the Unified Health System. Piola et al. (2013) cite that the total spending by the federal government, states and municipalities rose continuously from 2000 to 2011: from USD 37.8 billion in 2000 to USD 96.7 billion in 2011. At the same time, the federal government's share of public spending on health fell from around 60 percent in 2000 to 44.7 percent in 2011. In the same period, the contribution from the states rose from 18.5 percent to 25.7 percent, and from the municipalities from 21.7 percent to 29.6 percent. It is evident that the approval of Constitutional Amendment 29 had impacts on each sphere of government and successfully upheld the constitutional principle of decentralization, increasing the state and municipal stakes in public health funding (Piola et al. 2013).

In comparative terms, total health spending in Brazil accounted for 9.5 percent of GDP in 2012, higher than the average among mid-high income countries (6 percent), but lower than that in high-income countries (11.6 percent) (WHO 2015). In absolute terms, this level corresponds to USD 1388 per capita annually.[13] However, only 47.5 percent of the total amount comes from governmental funds allocated to the SUS (WHO 2015). This is clearly incompatible with the pattern found in developed countries, many of which have universal public health systems, and where the level of public resources tends to exceed 70 percent. In terms of private resources, monthly fees for health care plans and insurance premiums in Brazil constitute an estimated 40.4 percent of total health expenditure, whereas out-of-pocket expenditures account for 57.8 percent (WHO 2015). It is clear, therefore, that a high share of private funding characterizes the pattern of health care financing in Brazil.

It is also important to point out that private health care plans and insurance schemes receive public funds in a variety of ways: by allowing public facilities under the SUS system to provide exclusive services to those with private schemes; by purchasing private health care plans for civil servants; and by offering income tax deductions for the health care expenses of individuals and companies, alongside other direct and indirect subsidies. All of these mechanisms reduce the proportion of money

[13] Purchasing Power Parity at international dollar rate.

available to the public system (SUS). Hence, the Brazilian government is in fact funding private health care plans and insurance premiums.

Another important issue is related to the efficiency of health expenditure. Considering the ratio of health outcome (life expectancy at birth) to health spending (total health expenditure per capita), Brazil is considered a low-performing country because life expectancy is lower than that achieved in other countries with the same levels of health spending per capita (Chisholm and Evans 2010). At the subnational level, evidence suggest that many Brazilian municipalities are underperforming in terms of efficiency of health workers in attaining coverage of antenatal care, with a wide variation in the levels of technical efficiency across municipalities, varying from 12 percent to 100 percent (Sousa et al. 2006). Problems were also reported in terms of medical technology and allocative efficiency at the facility level (for example, high-cost equipment installed in municipalities that do not have the size or the role to host it) and of hospital efficiency (for example, small scale of operations, high use of human resources, and low use of installed capacity and technical resources) (Gragnolati et al. 2013).

In light of such considerations, the reforms needed to achieve stable and sufficient financing to uphold the principle of universality are:

- Increased government expenditure per capita in the public health care sector;
- Reduced weight of private expenditure in total health expenditure;
- The adoption of new criteria for the allocation of federal government funds;
- Greater flexibility in the use of funds transferred to states and municipalities; and
- Managerial innovations that reward the efficient use of resources.

Strategies for Science, Technology and Innovation in the Health Sector

An analysis of federal policies on science, technology and innovation in health reveals institutional complementarity between the industrial sector and health services in Brazil. Policy instruments to increase domestic production of health technologies were adopted by the Brazilian government

over the last 15 years. These instruments are geared towards scientific and technological development (stimulating innovative processes), the strengthening of which requires a relationship with the private sector. Among the instruments available for this is the use of the procurement and financing mechanisms of government agencies that promote production and innovation, such as the Brazilian Development Bank (BNDES) and the Funding Authority for Studies and Projects (Finep).

With regard to health care itself, priorities established in national health policy are now used to inform research and development activities. This means that these activities should satisfy public health needs and help to address inequalities in access to the health system, broadening and strengthening the principles of the SUS. Such is the case with the domestic production of antiretroviral drugs used in the treatment of HIV infection which supply the National Sexually Transmitted Disease/AIDS Programme, many different hyper-immune serums and antivenins, reagent kits for laboratory diagnoses, different types of vaccines to respond to the public health demands of the Brazilian vaccination schedule of the Ministry of Health, blood products to make Brazil self-sufficient in the blood products sector, and the production of basic medicines for people who live with haemophilia, genetic or acquired immunodeficiency, cirrhosis, cancer and HIV/AIDS, as well as for burn victims.

Strengthening the complementarity between the industrial and health sectors is crucial, since many of the challenges the Brazilian health system faces can be found in the interface between these two sectors. These challenges include a strong dependence on foreign sources for health supplies and technologies; increasing health costs; growing commercial deficits in low value-added products manufactured by Brazilian companies in the health care value chain; limited links between health policy and other public policies, whether policies aimed at economic growth or those for social protection; weak connections between the Ministry of Health's internal plans and policies; significant regional inequality in access to health services, especially services requiring complex technologies; and significant regional inequality in services offered.

The federal government is a major protagonist in the area of science, technology and innovation in health care for a number of important reasons: it defines health priorities (such as the National Agenda of Priorities for Health Research and the List of Strategic Products for the SUS, both

compiled by the Ministry of Health in recent years); it finances research and infrastructure (approximately USD 500 million in research grants from the Ministry of Health budget since 2002); and it purchases equipment, medicines and other strategic technologies (the Ministry of Health purchases over USD 8 billion in health technologies annually). Various initiatives can be identified that use government procurement to drive national production in the area of health. These include Partnerships for Productive Development (*Parcerias para o Desenvolvimento Produtivo*, PDP) and the granting of preferential margins in the purchase of national products.

PDPs are partnerships between public institutions and private companies that aim to expand access to health technologies considered a priority for the country. These partnerships are expected to reduce the vulnerability of the SUS in the long term by internalizing the production of high value-added technologies at a lower cost, including pharmaceuticals, medicines, blood products, vaccines, serums, biotechnological products and medical devices, among others. As of August 2014, the federal government, through the Ministry of Health, had established 104 partnerships covering 19 public laboratories and 57 private companies engaged in manufacturing 97 different health products, primarily drugs and vaccines. It is estimated that the manufacture of these products in the country will mobilize USD 4 billion per year in government procurement, resulting in annual savings of USD 1.5 billion, with a reduction of equal value expected in the trade deficit.[14]

In addition, the Brazilian government has implemented other initiatives to strengthen the local production of strategic technologies and, thus, reduce the technological dependence and vulnerability of the SUS (Brazil 2013c). This includes the establishment of a margin of preference of up to 25 percent in open bidding conducted within the federal government for the purchase of drugs and medical devices developed in Brazil, and the creation of specific lines of credit operated by the main funding agencies for USD 3.5 billion by 2017.

[14] Some products manufactured via PDP are already being acquired by the Brazilian Ministry of Health, such as clozapine, imatinib mesylate, olanzapine, quetiapine, rivastigmine, tacrolimus, tenofovir and some vaccines (Brazil 2013b). Figures retrieved from http://www.blog.saude.gov.br/index.php/570-destaques/34290-saude-cria-nova-regulacao-para-a-producao-nacional-de-medicamentos-e-equipamentos (accessed July 2015).

Although there are significant changes under way in the Brazilian regulatory framework for science, technology and innovation in health care, it needs to be stressed that changes in policies on production and innovation are not sufficient. This discussion should be accompanied by institutional transformations that effectively reduce moral risks, including bias in favour of particular businesses or political groups. This leads to the question of the evolution of productive health care arrangements or models—involving producers of supplies, medications and equipment, health care services and public research and production institutions—and how they functioned together, or combined, before and after the foundation of the SUS (Viana and Silva 2012).

The first productive health care model has the main characteristic of being public and national, as it is composed of public services and institutions, relies on public financing and has a low degree of external dependence. This constitutes a genuinely national scientific development in the field of biotechnology (serums and vaccines). This first model was constructed and has evolved since the First Republic (1889–1930). It involves federal and state governmental bodies of health services and the development and coordination of public institutes of science and technology created in the late nineteenth and early twentieth centuries, such as the Oswaldo Cruz Foundation, a scientific institution for research and development founded in 1900, and the Butantan Institute, a biomedical research centre founded in 1901.

The second productive care model developed from the 1930s onwards from the health care services provided to individuals insured by social security. Unlike the first model, this second arrangement is essentially of a private and international nature. This model predominantly offers private services (associated and contracted private hospitals and laboratories). It receives mixed (public and private) funding and has a chain of global producers and suppliers of materials, medicines and medical equipment. Hence, it involves heavy external dependence on imported health technologies, characterized by growing deficits in the balance of trade of products in the industrial-economic complex of health care, especially during the first decade of the twenty-first century.[15] Table 7.4

[15] Estimated trade deficit for 2014 is approximately USD 11 billion.

Table 7.4 Characteristics of the two productive health care models in Brazil

	Model	
Characteristic	Public-national	Private-international
Origin	1889–1930	1930s onwards
Emphasis	Public health actions and programmes (immunization, health surveillance etc.)	Individual health care attached to social security (specialized care + hospitalization)
Delivery of care	Mostly public (primary care facilities) + private non-profit (charitable hospitals)	Mostly private for-profit (medical clinics and hospitals)
Funding	Public	Public and Private
Science, technology and innovation development	National Public pharmaceutical laboratories Mainly serums and vaccines	International Foreign companies Mainly drugs, medications and medical devices
Degree of external dependence	Low	High

Source: Based on data from Viana and Silva (2012)

summarizes the main characteristics of the two productive health care models in Brazil.

In the history of Brazil's national health policy, these two models have been combined in various ways according to patterns of development. In the current period, the first public-national model provides a basis for health system reform, as illustrated in specific policies to promote science, technology and innovation activities and support the industrial-economic complex of health care. This has occurred simultaneously with the expansion of public health services, especially in the poorest regions of the country such as the Northeast, through increased public hospital and outpatient service capacity.[16] However, the second (private and internationalized) arrangement is also expanding through increased levels of coverage of private health care plans by means of the geographically

[16] Roughly 70 percent of the health establishments in Brazil that do not offer hospitalization are now public, while the gap between the number of public and private hospital beds is shrinking (IBGE 2010).

concentrated expansion and intense capitalization of the companies that sell health insurance and plans. At the same time, recently approved legislation[17] allows foreign investors to invest openly in Brazilian hospitals and other health facilities, a measure expected to stimulate private investments in the health care sector, which tends to reinforce the private and internationalized model.

The question that arises, in light of this scenario, is how can a sound association between health and development be ensured? In other words, what needs to be done so that the productive care arrangements in the field of health contribute to a synthesis between the public and collective framework for welfare and social inclusion and the logic of the private, individualist market? The answer to this question necessarily involves the acknowledgement that it is the role of the state to define and coordinate public policies to integrate the multiple dimensions of development: scientific, technological, industrial and social. It is our understanding that the state is the key to the establishment and regulation of this process and that its role is to help combine market interests with public health concerns.

Conclusion

Studies and reflections on specific issues relating to the Brazilian health care system must take into account the challenges and contradictions of the economic processes and political choices that have been involved in the operation of a social state still under construction. The challenges posed today to the consolidation of the SUS are closely associated with the ways in which Brazil has navigated a wide range of policies, creating a space for a struggle or confluence of political and ideological positions in search of public policies aimed at building a fairer and more egalitarian society.

The institutionalization process of the SUS, especially since the 1990s when political and ideological differences clashed most visibly, has created a space in which many solutions could be tested and implemented

[17] Law 13097, of 20 January 2015, which amended Law No. 8080/1990, alters Law 8080, of 19 September 1990.

to expand access for all Brazilians. This is illustrated by the implementation of several successful initiatives, including those focused on the health family strategy, the national immunization programme, HIV prevention and AIDS treatment, pharmaceutical care, etc. However, the country still faces many challenges in order to increase the degree of universality in terms of population, costs and services covered by the system.

The three challenges discussed in this text—the regionalization and expansion of the public health care system; stable and sufficient funding to uphold the principle of universality; and the regulation of science, technology and innovation activities and public–private relations in health care—highlight the difficulties involved in moving towards universal social policies in a context of great social inequality, chronic underfunding and great technological vulnerability of the health care system.

The return of the state as the strategic agent in supporting development in Brazil opens a window of opportunity to create a virtuous complementarity between health and development. The strength of this complementarity obviously depends on the capacity of the government to propose and implement public policies in partnership with other actors of society, such as private companies and social movements. It also depends on whether the government has a long-term and integrated perspective that links the health sector to the long-term socioeconomic development of the country.

As correctly stated by some studies (Paim et al. 2011), the challenges facing the SUS are ultimately political. They cannot be fully resolved in the technical sphere; they can only be resolved through the concerted efforts of individuals and of society.

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8

What Kind of Welfare State Is Emerging in China?

Stein Ringen and Kinglun Ngok

Introduction

China is joining the family of countries that have reasonably comprehensive systems of social protection in place. In 2010, the National People's Congress adopted the first national Social Insurance Law, representing the culmination to that time of a process of radical social reform. The question raised in this chapter is: what kind of welfare regime is being built in the People's Republic of China?

China has been politically unique in the world. It is one of only five remaining communist party-states, the others being Cuba, Laos, North Korea and Vietnam, and the only one (with some qualification for Vietnam) to have been economically successful. The characteristics of a communist party-state are that power is in the hands of a party elite and that this elite is presumably motivated, more or less strongly, by some kind of socialist ideology of statism and social justice.

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Yet, while maintaining its political uniqueness, China has abandoned its economic uniqueness. With the reform and opening up that started in 1978, it turned its back on planned economy isolationism and has adopted an open "socialist market economy".

In the comparative welfare state literature, there are two main theoretical lines for explaining welfare state developments. The economic hypothesis, which originates with Wilensky (1975), sees the welfare state primarily as a reaction to economic forces, notably the level of development. We call this "the economic hypothesis". The second line, challenging that theory and originating with Korpi (1983), sees it primarily as a product of political action driven by power relations. We call this "the political hypothesis".

The economic hypothesis would lead us to expect the development in China of a reactive welfare state similar to that found in other market economies of roughly the same level of development, a welfare state of necessity. There is support for this hypothesis in previous literature. Cook et al. (2003: 71) describe Chinese social security reforms as "designed to absorb the shock of entitlement collapse (loss of employment); to deliver relief rather than development; support short-term consumption rather than reduce long-term poverty or vulnerability and to deal with symptoms rather than causes."

The political hypothesis would lead us to expect a proactive welfare state that is different in nature from that in economically similar countries, a welfare state of normative purpose. There is also some support for this hypothesis in the literature. Zheng (2008) sees current reforms as a stage in a politically directed development towards a genuine welfare society, an ambition to be realized gradually over the next decades and possibly consolidated by the centenary of the revolution, in 2049.

Our question in this chapter, then, divides into two: Is China producing a welfare state of its own kind, possibly a "socialist" welfare state? Or, if it is reproducing a conventional welfare state, what kind of previous experience elsewhere is it following?

Similar to or Different from What?

The literature on welfare state regimes has produced a raft of classifications based on policy design. The effort originates in Titmuss's (1974) intuitive division of welfare states into three models by social policy design: the

residual model, the industrial achievement–performance model and the institutional redistributive model. This typology was later given empirical grounding by Esping-Andersen (1990), with the categories renamed liberal (or residual), conservative (or corporatist) and social democratic (or universal), and some revision in subsequent work (Esping-Andersen 1996, 1999a, b).

This is the baseline typology in the literature, but it is also contested and the attractively simple three-model scheme has not survived. There are four main objections to this earlier classification: that it is static; that it is theoretically biased; that it is based on too narrow an observation of social policy arrangements, mainly social security; and that it is based on too narrow an observation of countries—OECD countries mainly—and among them with not enough detailed attention being paid to the Southern European and Antipodean ones.

The first objection is that welfare capitalism changed substantially from the 1990s onwards and that the regime differences identified in data from the 1980s have been modified in a trend of convergence (Gilbert 2002). However, although welfare states may in some ways be converging, there is no agreement in the literature that the very distinction between models is obsolete.

The second objection has come mainly from feminist theorists to the effect that typologies based on "decommodification" through social security arrangements disregard family structures, gender roles and relationships between work and care.[1] This objection has been absorbed in the typology literature through increased attention being paid to family policies. Family policy in this context is taken to mean arrangements to alleviate the cost to parents of childrearing and to alleviate and equalize between genders the burden of child and family care. For example, in the Nordic model, with generous parental leave provisions, the parental leave allowance of up to about a year can be shared between the mother and the father—and indeed some of it is available only to the father.

In response to the third objection, other classifications have been suggested based on alternative social policy observations, including health care systems (OECD 1987), social assistance (Gough et al. 1997) and

[1] Orloff (1993), O'Connor (1993), Sainsbury (1993, 2001), Daly and Lewis (1998), Lewis (1992).

family policies (Guo and Gilbert 2007). These approaches tend to cluster countries differently than the way adopted in the Titmuss–Esping-Andersen typology. Britain, for example, is in the least "progressive" model in their typology but in more "progressive" categories in the health care and social assistance classifications.

The recurrent finding in research following on from the three-regime typology is that countries that are similar in some policies, differ in other equally relevant policies. One way to accommodate a broader range of policy observations, it has been suggested, is to move to a multidimensional approach (Bonoli 1997). The increasing attention to family policy is a development in this spirit.

Following this lead, we now suggest the introduction of a new dimension in welfare state classification, which we call "order versus fragmentation". Welfare states should be described, we suggest, first in terms of their policy design, as is conventional, and then, in addition, by the degree of order or fragmentation within any design. The underlying rationale is that what determines how well social policies work, for example, in poverty protection, is not only the kind and scope of social policy in a country but also how well, within any system, the different components work together. This has come sharply into focus in the analysis of the Southern European experience. These welfare states are distinctive less by a separate design than by being fragmented and comparatively ineffective. If we look, in contrast, at the Nordic countries, what they have in common is as much order as similarity of design. In fact, they are more divergent in terms of design than is often recognized (Erikson et al. 1987). In so core a component as pension systems, for example, Sweden and Norway adopt one kind of system—"people's pensions"—and Denmark adopts a different one—basic and earnings-related pensions managed separately, the latter under the "corporatist" management of labour market partners. They also differ in the area of family policy, where Finland and Norway on the one side and Denmark and Sweden on the other pursue radically different combinations of home care and outside-of-family services (Gilbert 2008). What they have in common is rather that their arrangements are "ordered": the safety net is tight, there are no loose ends, different components are coordinated and reasonably pull together, and poverty protection is effective.

"Order" in this meaning would reflect, firstly, the degree to which the welfare state in a country has provisions in place in all core elements of social protection. These are: (i) a last-resort safety net of social assistance; (ii) the main components of social security (income security in old age, illness, injury and unemployment); (iii) access to basic health care and welfare services; and (iv) family policy (family support arrangements). It would reflect, secondly, the effectiveness of provisions in respect to their purpose and how well the various provisions are coordinated and work together. In this dimension, the question is not how provisions are designed, for example whether social security is by state provision or insurance, but how functional they are. Order versus fragmentation is obviously a continuum, so that the question for any specific country is whether its provisions lean towards one or the other poles.

Combining design and order, then, we would find, for example, that the Nordic countries are universalistic and ordered, Germany conservative and ordered, and the Southern European, and probably Eastern European countries, conservative and fragmented. The United States is liberal and fragmented (along possibly with the Latin American countries), while Canada is liberal and ordered (along with possibly Australia and New Zealand). South Korea offers a typical example of an ordered developmental welfare state which has "graduated" to becoming more typically an ordered conservative welfare state.

This all makes for a rather complicated typological map such that the question of where a new member of the welfare state family fits in is not answered simply by slotting it into a model pigeon hole, but rather by going through a checklist to establish its various characteristics. In the case of China, the relevant checklist would be as follows:

1. Is China inventing an original welfare state of its own making? If the answer were yes, the task would be to describe the workings of this new model and the rest of the checklist would be academic. But in the more likely event that China is doing more or less what others have done previously, there would be further checklist questions to go through.
2. Is China producing a "socialist" welfare state?

3. Is the welfare state in China developmental? The reference would be the East Asian Tigers—in particular South Korea.
4. Does the Chinese welfare state contain a family policy component? The question here is whether there are provisions, in addition to those that might modify income and class inequalities, designed to modify family and gender inequalities.
5. Is China producing a hybrid welfare state that combines progressive provisions in some policy areas with, say, conservative or liberal designs in others, as seen most typically in the British case?
6. Is China producing a mainstream liberal or conservative welfare state, the references of comparison being the American and German models?
7. Is the welfare state in China, however it is being designed, ordered or fragmented? Are the main components in place and are they coordinated for effectiveness?

A Short History[2]

Following the formation of the People's Republic in 1949, the new rulers set about establishing a socialist economy. A universal lifelong employment policy was adopted in cities. All able-bodied adult citizens were organized into different work units (*danweis*) through job assignment by the government. Comprehensive welfare packages were provided for workers through *danweis*, which refers to state-owned enterprises, state agencies, government departments and other organizations in the public sector. Functioning as a self-sufficient "mini welfare state", the *danwei* system was composed of three basic elements: job tenure (iron rice bowl), an egalitarian wage (big rice pot), and a welfare package (Lu 1989). Prior to the economic reform since 1978, more than 80 percent of the urban labour force was covered by the *danwei* system (Wong 1999). In rural areas, farmers were organized into communes based on the collective ownership of land. Farmers worked for the communes through which daily necessities were distributed. For those urban residents who did not belong to a *danwei*, some social relief

[2] This section draws on Lieberthal (2004), Wong (1999), Joseph (2010), Saich (2008, 2011); Chan et al. (2008), and Zheng (2008).

programmes were set up to take care of their basic needs. For the poorest rural households, a "five guarantees" system funded by rural collectives was developed to cater for their basic needs (Chan et al. 2008). This welfare regime, though characterized by a sharp urban–rural divide and a low level of welfare provision, did provide basic social protection for both workers and farmers (Leung and Nann 1995).

Whatever the merit of that vision, it broke down during the Cultural Revolution (1966–76). From 1978 onwards China now embarked on great reforms towards developing a socialist market economy. The provision of security by way of guaranteed access to jobs or land was discontinued. Gradually, it became accepted by the leadership that a market economy cannot function without the support and lubrication of some kind of social protection and that something that could function in conjunction with a market economy had to be put in place instead of the old provisions. This understanding took time to mature, however. What can be described as systematic social reform towards a welfare state did not take off until the late 1990s, initially in the form of local experimentation. Consolidation towards a more inclusive system started around the end of the decade and moved forward into the new century, under the ideological guidance of Hu Jintao, Chinese Communist Party (CCP) General Secretary from 2002 until 2013, and Wen Jiabao, Premier from 2003 to 2013, and their "building a harmonious society" and "putting people first" slogans.

The outsourcing of social responsibility from work and production units was taken forward in a painful process of trial and error. The old support system was dismantled early on while a new system emerged gradually, tentatively and much later. The interim was a period of policy neglect, social chaos and misery.

In the initial reform period, the leaders were in confusion about how to deal with "the social question" with which they had landed themselves. In part, it was believed that social problems would dissolve as a result of economic growth, and in part that social protection, to the degree that the notion was recognized, was contrary to economic growth. In the first years after 1978, measures were taken to restore the structures of protection that had been destroyed during the Cultural Revolution, yet these were counterproductive in an era of market reforms and, in subsequent years, China

found itself in social limbo with little in the way of effective provision for those who were not lifted out of poverty on the wave of economic growth. Large numbers of the population were, indeed, lifted out of poverty, but many more were left in destitution. In rural areas, for instance, the dismantling of collective structures meant that social protection evaporated for most farmers, including the old cooperative health care system. Rural clinics became private practices and the farming population was left without access to basic medical care. In urban areas, the policy of full employment was dismantled and replaced (as of 1986) with a system of individual contracts, and enterprises freed from employment and welfare responsibilities. Large numbers of workers were laid off and many employers reneged on, or were unable to honour, wage and social obligations, resulting in increasing poverty deep into the working population. Migrants gravitated to cities on subsistence wages and without access to any social support. Education, health care and housing became widely unaffordable. Patients without money were rejected by hospitals as were students in economic hardship by schools and colleges. The resulting misery gave rise to widespread and serious social unrest, including strike actions, throughout the country during the late 1980s and 1990s, on a regime-threatening scale beyond what has generally been recognized outside of China.

The first phase of serious social reform was to resurrect comprehensive measures for the traditionally privileged groups: public sector and urban formal sector workers. For these groups, urban social assistance, health insurance and pensions were operational by the end of the 1990s. As of 2002, experimentation with rural pension insurance was stepped up and rural medical insurance was introduced in 2003. In 2006, agricultural taxes were abolished. In 2007, free compulsory education was introduced for rural children and in 2008 this was extended to the whole country (although not consistently to migrants' children). In 2007, the leadership pledged to extend the Minimum Subsistence Guarantee to rural China. Migrant workers were, in principle, given access to pension insurance in 1999 and to work injury insurance in 2002. In 2002–2003, migrant workers were accorded the status of being part of the working class and the right to equal treatment with urban residents when applying for work, and urban education departments were obliged to recognize schools for migrant children and to offer these children equal access to education.

These reforms have radically changed the structure of the support system. At the beginning of the reform period, urban households had upwards of 40 percent of their income from social benefits, the bulk being made up of food and housing support. By 2007, the share of social benefits in urban household income was down to 20 percent, the bulk now being made up of social insurance and with housing and food benefits almost eliminated (as estimated from survey data by Gao (2012).

The reforms were backed up by legislative, administrative and other policy signals. The concept of social security was first used in a high-level policy document in 1986 (the Seventh Five-Year Plan). In 1993, the CCP issued a general decision on the establishment of a socialist market economy system in which social security was identified as "a normal sustaining mechanism" and the main components of a social insurance system were outlined. In 1994, the State Council issued a "Seven-Year Priority Poverty Alleviation Programme (1994–2000)". In his political report to the National Congress of the CCP in 2007, General Secretary Hu articulated the theme of "social development" (the literal translation of the Chinese term is "social construction") and the right of all citizens to education, employment, medical care, pensions and old age care, and housing. In his political report to the 18th National Party Congress in 2012, Hu again stressed the importance of "social development", the key meaning of which is to guarantee and improve people's livelihoods and to satisfy their increasing material and cultural needs. Xi Jinping, the newly elected General Secretary of the CCP in 2012, articulated the party's overall goal as to providing a good life for the people.

The Current System

Two decades of reform have produced a welfare system that stands on three pillars (Zheng 2008): social assistance (the basic provision), social insurance (the main body) and welfare services.

Social assistance, in the form of poor relief, is a centuries-old tradition in China and statutory poor relief dates back to at least the 1943 Law on Social Relief and Assistance. Today, the main form of such provision is the Minimum Subsistence Guarantee. This gives access to a locally

determined minimum subsistence level of cash support, conditional on the level of family income. The relief is managed and funded locally, with some central or provincial government subsidy. Urban residents with urban resident permits have, in principle, been covered since 1999 and rural residents since 2008 (supplementing the existing rural "five guarantees" provision of assistance to so-called extremely needy households). Migrant workers are excluded from entitlements in the scheme, but can be partially covered, depending on local practices. Some other forms of discretionary assistance may be available, such as emergency relief, assistance for homeless people and the destitute, and education, medical and housing aid, again depending on local practices. The level of minimum subsistence is low and basic, and with huge local variations notably between (but also within) urban and rural areas. Both the right to support and the duty of provision are ambiguous.

Public social assistance may be supplemented by various forms of encouraged quasi-governmental and quasi-voluntary charity, mainly in the form of assistance in kind, yet again depending on local practices.

There are five categories of social insurance: pensions, medical, work injury, unemployment and maternity. The basic social insurance is and will remain state run and state owned. Citizens can purchase additional private insurance, but they are not allowed to opt out of the state system altogether. The general structure is that funding is through social pooling whereby employers, employees, the self-employed and the state, in various combinations, contribute to funds, while entitlements are gained by contributions and, in the case of pensions and medical care, regulated by personal accounts. This model is adapted from previous experiences in, for example, Singapore and Chile.

There are three categories of pension insurance: for urban enterprise employees, for other urban residents and for people living in rural areas. The majority of employees in government and party organizations have pension entitlements through separate schemes, which are not organized as insurance. In some localities, civil servants are covered by the pension insurance for urban enterprise employees. The retirement age is normally 60 for men and 55 or 50 for women.

Enterprise employees, mainly urban, have access to a basic pension insurance, which is obligatory, and may have access to supplementary

enterprise pension insurance. The basic pension is state run on the principle of social pooling and personal accounts. The supplementary pension is additional to the basic pension and is enterprise run, or run jointly by pools of enterprises, for the enterprises' own employees. Additional personal (commercial) pension insurance is also encouraged. The aspiration is that basic, supplementary and personal pensions for enterprise workers should add up to a replacement rate at about 60 percent of the wage at retirement, but that is unlikely to be achieved in any uniform manner in the foreseeable future.

The basic pension insurance is, in principle, obligatory for employing enterprises and employees. Contributions are paid by both employers and employees, with the employer collecting the employee contributions. Employee contributions go into a personal account, the content of which is personal property. It cannot be withdrawn until retirement or used for other purposes, but any balance in the account on the death of the person is inheritable wealth.

The pension is estimated from employer and employee contributions, the local wage level, demographic (life-expectancy) factors and over-time indexing rules. Pensions are payable after a minimum of 15 years of contributions, at a level such that members who have contributed for the minimum of 15 years should receive a pension equivalent to approximately 15 percent of the average local salary, and with an additional one percentage point for every additional year of contribution.

The basic pension insurance is available, but not obligatory, to other categories than enterprise employees, including, for example to the self-employed, migrant workers, workers in part-time or irregular employment and certain urban residents without work, all of whom, however, have to carry all contributions themselves.

Government and party employee pensions, including military pensions, are non-funded and are fully covered from government budgets, and arranged as final salary defined benefit schemes. These employees have privileged pension entitlements in comparison with enterprise employees, for example at replacement levels after 35 years of service of up to 90 percent of the salary at retirement.

Except for a small group with prior employment in state-owned or collective enterprises, pensions for rural residents lag behind provisions for

urban residents. However, pension insurance for rural residents has been rolled out gradually since 2003, covering an estimated 326 million people by the end of 2011, up from 240 million in 2009. It is set up on a similar structure to the basic enterprise pension insurance, including with personal payments into personal accounts, but with a "collective and government subsidy" in the place of the employer contribution. Pensions from the rural system are at a lower level than those from the enterprise system.

The public medical insurance is in three components: basic medical insurance for urban enterprise employees, basic medical insurance for other urban residents and rural cooperative medical insurance for the farming population. The enterprise medical insurance is obligatory for employing enterprises and employees, with contributions paid by both parties, and available to others, such as the self-employed, who are obliged to pay all contributions. The level of contributions in the enterprise scheme is about 6 percent of salary costs for employers and 2 percent of the salary for the employee. Enterprises may set up supplementary medical insurance for their employees. In the non-enterprise medical insurances, contributions are paid by persons and the state. Contributions to be paid by the unemployed or those on social assistance are subsidized by the state.

The basic insurance is set up to cover a part of medical expenses for the participants—both working and retired (provided sufficient accumulated contributions)—but not all expenses or all treatments. The portion of medical expenses covered by the insurance is to be settled directly between the social insurance agency and the providing institution. The government provides additional medical allowances and services for government and party employees, military personnel and veterans. Social assistance recipients may have access to additional medical assistance. Service provision comes through institutions and pharmacies, which are designated service providers of medical insurance and which may be private. Community health service centres or hospitals are in operation in both urban and rural areas to provide basic care and preventive health education and guidance. Health related social control, such as family planning, is provided mainly by separate family planning service stations or centres.

The new rural cooperative medical insurance scheme was begun in 2003 and is now being implemented on a nationwide basis. By the end of 2011, 97 percent of the farming population was covered. It is a vol-

untary scheme for rural residents, which aims to cover medical costs for the treatment of serious diseases. The contributions are from central and local governments, rural collectives and premiums paid by participants in the scheme. In 2012, the standard financial subsidy for every insured farmer is 240 yuan per year, and the personal contribution 60 yuan per year. Reimbursements from the scheme are very low compared with the basic medical insurance for urban enterprise employees.

Workers who are covered by the enterprise medical insurance scheme are entitled to a fixed period of paid sick leave, based on their years of service. For others, the medical insurance does not cover the loss of wages during illness.

The work injury insurance is obligatory for employing enterprises and funded fully by employer contributions (no employee contributions). The contributions are set at a level adequate to cover running expenses and are variable across regions, sectors and enterprises according to incidences of work injuries. There are three main compensations: medical and nursing allowances, disability allowances, and allowances for work-related deaths, including funeral allowances and conditional allowances for family members. Wages during the treatment period (normally for up to 12 months) are to be carried by the employer. Employers who evade payment of insurance premiums are liable to cover the insurance benefit. The insurance does not cover the consequences of permanent loss of working capacity, nor of self-inflicted injuries, such as those resulting from drunkenness.

The unemployment insurance is obligatory for employing enterprises and is funded by both employer and employee contributions. It provides sustenance (living and, conditionally, medical expenses) for unemployed workers for a duration of up to 24 months. There are also provisions to support employment or re-employment. The scheme covers urban enterprise employees and employees of certain social organizations and privately owned non-enterprise institutions, and, conditionally, the urban self-employed (either with or without employees). At the time of writing, the introduction of a scheme of unemployment insurance for migrant workers who have labour contracts with urban institutions covered by the unemployment insurance is under consideration. Non-employee residents are not included, such as farmers who have lost farmland due to, for example, local government expropriation.

Re-employment policies include the issuing of "re-employment support certificates", support of vocational training and other forms of re-employment and job-seeking training and assistance, and the encouragement of self-employment. Absent from the Chinese system, including in social assistance, are work-fare provisions (where support is given conditionally on the claimant actively seeking work), something that has become a standard component of the welfare regime in many other countries.

In the maternity insurance scheme, female employees have a right to compensation for the loss of salary and for medical expenses incurred during childbirth (or undergoing abortion). The insurance is funded fully by employers at a regionally differentiated rate of no more than 1 percent of the employer's salary costs. The birth allowance entitlement is at a local average salary level and for no less than 90 days.

Welfare services are traditionally a local responsibility and have been provided for the most disadvantaged groups, such as the poorest elderly, orphans and disabled persons. Provisions continue to be selective. Social services for the elderly are targeted to "needy" or "extremely needy" groups, and integrated into the urban and rural social assistance systems. Services are distributed mainly through institutions (senior citizens' homes), which provide accommodation, in-house services, emergency aid, daytime care, health and rehabilitation services, and recreational services. Most townships and urban communities have established institutions of this kind.

Social services for children are targeted to orphans and abandoned or disabled children and provided mainly through institutions (children's welfare houses, boarding schools and the like). Adoption and foster care is encouraged.

Social services for disabled persons are targeted to persons with "disability certificates" and are in the form of a basic subsistence guarantee (social assistance), special disability allowances, and special education, rehabilitation and employment services.

Public housing was a central component of social support in the pre-reform period, but is now discontinued. Public housing property has been mostly privatized through subsidized purchasing. What remains of housing policy is limited to the injection of affordable housing in the hous-

ing market and the provision of subsidized mortgages. This represents an unloading of state social responsibility on to private wealth accumulation through the expansion of home ownership. Although this has been quite successful in most urban centres in the creation of a new property owning class, it has come at the price of undermining poor people's access to affordable housing and of new inequalities and class divisions.

Absent from the Chinese model at the present time is any articulated component of family policy.

What Kind of Welfare State?

This description of the Chinese welfare model, as it stands today, must be accompanied by significant disclaimers. All the components that are listed above exist and are in operation. But there are also significant divisions, differences and shortcomings across the system in terms of the implementation on the ground. The description, therefore, should be read as reflecting in part operating policies and in part policy aspirations. What is actuality and what is aspiration cannot be stated in any precise manner.

The system of funded social insurance is currently being developed, with huge unresolved problems of implementation pending. The main aspirations are to move the management of social security from firms to state and societal agencies, to create more uniformity across sectors with more equitable provisions for workers in state-owned and private enterprises, and to start the building up of funds to help finance future needs.

The collection of social insurance contributions and the distribution of benefits are in the hands of county social insurance bureaus, operating through local suboffices. (The county is the second level of local government, below the provincial and above the town and township levels.) Both contributions and benefits are to some degree at the discretion of local authorities and neither is uniform across the country.

The plan is to collect more in contributions than is paid out in claims, with the intention of the scheme accumulating social insurance capital to underwrite future claims. This is to manage the growth in claims that are coming down the line in terms of the ageing of the population. The capital is to sit in funds, the management of which (according to the

2010 Social Insurance Law) is gradually to be centralized to provincial governments, and in the case of pension funds to the central government. This centralization is ongoing, against much local resistance, over an unspecified timetable.

There are built-in impediments to putting in place the structure of local collection of contributions and the payment of claims and central control over the capital. Although outlays are supposed to be covered by contributions, it is also provided that local authorities have the power to define provisions in respect to local circumstances and that the central government is the financier of last resort to cover any deficit. This gives all authorities below central government level an incentive to keep contributions low. Furthermore, since any surplus is shifted up the chain, county governments have an additional incentive to keep contributions low, or, if they run a surplus, to siphon it off to their own uses. These incentives are strengthened by a regulation whereby surplus social insurance capital is to be invested mainly in central government bonds, which yield notably low returns. Both provincial and county governments may therefore have an interest in putting their capital to better use locally rather than to pass it up the chain and into the hands of central authorities.

The experience so far, as confirmed in official audits,[3] is that the system, in all components of social insurance, is shot through with irregularities, such as non-participation by enterprises, shortfalls in contributions, the mispayment of benefits to non-eligible persons, excessive overhead costs, and very considerable misappropriation locally of social insurance funds, including by corrupt means. Although the system as a whole (according to official statistics) is running at a surplus, there is, as yet, very little accumulation of capital so that what on paper is becoming a system of funded social insurance, de facto continues to be run on a pay-as-you-go basis so that by and large today's contributions pay for today's benefits (*The Economist*, 11 August 2012).

In 2000, the central government established a National Social Security Fund, which is managed centrally under the National Council for Social Security. This fund operates in part as an international sovereign investment fund, and also absorbs other capital that the central government

[3] See www.audit.gov.cn/n1992130/n1992150/n1992500/3071265.html. Accessed March 2016 (website in Chinese).

may allocate for the purpose. It is to be used to meet central government obligations throughout the system, such as to smooth out local variations, and to underwrite future demands.

With the provisions that are now in place, China is currently approaching near-universal access to basic normal components of social protection. However, this statement needs to be qualified in five ways.

First, access is moving towards "near universal", but not fully universal. The 2010 Social Insurance Law carefully envisages wide coverage. The main remaining and unresolved exclusion is that of migrant workers, numbering perhaps 250 million people. There are two reasons for this. One is the household registration system, the *hukou*, whereby most migrant workers have social rights where they are registered but not where they work. There is ongoing consideration (and local experimentation) about replacing the old *hukou* with a nationwide resident permit system, which would give migrants social rights where they work (this is envisaged to happen in the 2010 Social Insurance Law), but there are many impediments, including local resistance, and no firm decision on this has been taken. The second reason is that migrant workers are widely considered second-class citizens and massively discriminated against even in the rights they do have.

Second, access is approaching near universality, but provision is not. For various groups—the self-employed and irregular workers, for example—participation in social insurance is voluntary and expensive, since they must pay all contributions themselves. Even where participation is compulsory by law, as it mostly is in the case of enterprise workers, there is widespread non-compliance and failure by enterprises to register. Social insurance entitlements are intended to be made portable so that workers retain them when changing jobs or relocating, but exactly what entitlements are portable is not clear and the practicalities of portability are not in place.

Third, when access is available, it is inadequate and not uniform. Social assistance has low efficiency in that the level of support is generally inadequate for protection against poverty, provisions are often poorly managed and there are built-in rigid work disincentives, poverty traps and dependency distortions (Zheng 2008). The Minimum Subsistence Guarantee is plagued by targeting errors, with very limited anti-poverty results being achieved (Gao et al. 2009; Gustafsson and Deng 2011). Welfare services

are minimal. There are missing components, notably the dimension of family policy, but also income security during illness. In social insurance, there are regional and occupational variations in provisions, including between government and enterprise employees and urban and rural residents, and to the disadvantage of migrant workers.

Fourth, central government intentions may be mismanaged, ignored or sabotaged at a local level. Local authorities have a great deal of autonomous power within the system. They have the power to interpret implementation duties and to regulate programme coverage and benefit levels. They can decide on the degree of inclusion or exclusion of migrant workers. They hold power over social insurance capital and have the power to divert these funds to uses of their own. They have vast spending responsibilities but also revenues of their own, for example land rent, and have the power to raise debt (which they may or may not be able to honour). Poor local authorities down to the village level have the power to be miserly and affluent ones to be generous, including through social provisions of their own. They also have the power of disobedience. The result is a system with limited and unequal implementation and vast and complex inequalities of provision across localities.

Fifth, in so large and complex a country as China, provision—the bringing of benefits and services to claimants and clients—is extremely difficult. Social assistance and social service benefits are provided by local government agencies and social workers, often with low capacity and not always with goodwill. Social insurance cash benefits are provided through local social insurance bureaus, which may be inefficient or corrupt. In both social assistance and social insurance, the payment of benefits and entitlements is poorly targeted and widely misallocated. Social insurance benefits in kind, such as health care, are provided by service institutions and practitioners, all of which, private or public, operate on a fee-for-service basis. This complexity, along with that of government levels, contributes to the pattern of vastly differentiated provisions across the country.

To facilitate provision, the government is encouraging the participation of quasi-voluntary agencies. These may be genuinely voluntary or quasi-non-governmental organizations set up by government agencies. Their operations are, for the most part, fully or partially funded by local governments. They are strictly registered, regulated and monitored. These

agencies operate under government auspices and supervision and do not collectively form what might elsewhere be considered a network of civil society institutions.

All things considered, then, China today operates an extensive system of public welfare. This is principally a social insurance system, biased in favour of the urban population, and with minimal and disjointed other provisions, including for last-resort poverty protection. It is without universality of coverage or provision and with a deep differentiation of treatment between population groups. There is, in fact, not one welfare state, but many radically different ones. The great divide lies between the urban and rural populations. Gao (2012) describes the urban welfare state as being similar to those operating in Western industrial countries and the rural welfare state as similar to those in least developed countries. While urban households receive about 20 percent of their income from social benefits, that share for rural households is a mere 2 percent. Between these two groups is the large population of migrant and other irregular workers, who have notably inferior social rights compared to regular urban residents.

Model Summary

We can now return to the checklist from the beginning of this chapter and summarize the characteristics of the welfare model that is coming into place.

First, is it original? The answer is no. What has emerged in the reform period is, in all respects, tested and conventional. The aspiration going forward is to improve the implementation on the ground of the provisions that are now formally in place, but there are no plans for the introduction of any new directions of reform. The 2010 Social Insurance Law codifies existing practices with no new principles of social protection proposed. The structures of social assistance, social insurance and social services that are seen to be necessary and appropriate are now thought to be in place and what remains is to get them to work. There are no plans for systemic improvements in social assistance, and hence in basic protection against poverty.

Second, is it "socialist"? The answer is no. The original thinking in communist China was sceptical of "welfarism" and in favour of perfecting a predistribution state on Soviet principles. That bold idea collapsed, and when the leaders came around to recognizing the need in their market economy for social protection, what they reached for were practices typical of capitalist rather than socialist economies, grounded on a principle of "basic protection" (2010, Social Insurance Law, Article 3). There is no ambition or intention, even among the most eager social reformers, of aiming for any kind of social democratic universalism. There is some statism in the keeping of the capital from basic social insurance under state control, but that hardly makes for a uniquely socialist welfare state and is, for example, a lower level of state control than in the Norwegian and Swedish "people's pensions."

Third, is the Chinese welfare state "developmental"? The answer is no. Superficially, there are many common features with the developmental experience in other East Asian economies—the supremacy of economic development, cautionary social provisions and a low level of public social spending. But what makes the developmental welfare state "developmental" is a proactive use of social protection as an instrument of economic development. That does not fit the Chinese case. Here, the official line, as a formally issued government guideline, has been "efficiency first, equity second" (CCP 1993). The 2010 Social Insurance Law, in its preamble, sees social protection as following from economic development as it becomes affordable. Social reform was not introduced early in the developmental phase but followed on later when the necessity of welfare lubrication was understood, when the adverse social consequences of GDP-growthism could no longer be swept under the carpet, when the country was mired in social unrest, and when some investment in welfare was seen to be affordable. What there was of early reform was helpless and ineffective, for example experimentation with micro-credit arrangements for poor households (Saich 2011). This is in contrast to the similar policy in South Korea, known there as the New Community (*Saemaul*) Movement, in which developmental seed-money was distributed from the state in rural areas in ways that stimulated vast local resources to be invested into development projects and succeeded in giving the rural population a feeling of being part of—and integrated in—the overall economic progress and modernization (Ringen et al. 2011). Other contrasts are in occupational

welfare and the role of voluntary agencies such as non-governmental organizations (NGOs). In Korea, the earliest effective method of social provision was for the government to coerce employers into providing occupational welfare and to being at least somewhat better employers. In China, employers were freed from employment and social responsibilities. In Korea, the government mobilized voluntary agencies on a grand scale for the delivery of social services, something that enabled the regime to be more social than it had economic and administrative resources to be by its own action. In China, the government has been hesitant to allow NGOs any autonomous role and has kept NGO involvement on a low scale and under tight control.

Fourth, does the Chinese welfare state include provisions of family policy? The answer is no. Although the level of maternity leave is quite generous, there is no articulation of any policy of economic and service support for childcare and gender equity. Official pronouncements in favour of women's interests and rights are mainly ceremonial. Village committees are obliged to earmark one post for women's affairs, but these posts are generally ineffective. China remains a rigidly gendered society around practices far removed from any notion of gender equity, both within and outside of family life (Lieberthal 2004).

Fifth, is there a hybrid welfare state in the making with some notably progressive components? The answer is no. There is consistency in what is being built: a low-level social insurance state supplemented by marginal social assistance and welfare services. Nowhere in this design does any component stand out as more progressive than it should be—for example, no national health service is envisaged, nor a rights-based system of social assistance.

Sixth, does the system that is coming into place fit the remaining main models of either a liberal or a conservative regime? Here, paradoxically in a communist state, we are getting nearer to an answer of yes. If anything, the Chinese welfare state is a hybrid of the least progressive models in previous experience. With the strength of statism within the system, such as in the control over social insurance capital, it is hardly liberal, but there is also ample space for private insurance, mainly in supplementary pension and medical insurances. What seems to offer the best fit is, paradoxically, the conservative model. The design is cautionary, aimed to provide secu-

rity but on no more than a basic or minimal level, the core mechanism being insurance divided along corporate lines, and all wrapped into a packaging of more or less traditional Chinese state paternalism.

Finally, is an ordered welfare state in the making in China? The answer is no. Social assistance is inadequate and those in need are not protected against the potential consequences of ill will or incompetence on the part of local authorities. There are missing components, notably the dimension of family policy, but also income security during illness. In social insurance, the scaffolding is up but the actual building work is being undertaken against much hesitation. There are huge shortfalls in the implementation of even obligatory provisions. Social management is poor in quality and arbitrary in implementation. Migrant and irregular workers, and the children of migrant workers, are without the rights that are otherwise defined in the system. The aspiration of securing long-term sustainability by transforming a pay-as-you-go system into one of funded social insurance is moving forward hesitantly and is far from being under firm central government control. Coordination between central and local authorities is poor and often conflictual. Regional and occupational differentiation is rampant. Welfare services are minimal and inequitable. Components are poorly coordinated, and the system shot through with differentiation, non-implementation and arbitrary practices. While improvements in the ordering of the system are likely in the years to come, the system of social protection as now defined, even if it were to work as intended, is not one that will afford the Chinese population near-general protection against poverty.

In terms of the economic and political hypotheses on the relative strength of economic versus political forces in welfare state development, the Chinese story so far is in support of the economic hypothesis. In China's communist party-state, we should have expected a welfare state of purpose, which is to say, a socialist welfare state. What we have, however, is a reactive welfare state of mere economic necessity. The People's Republic is producing no new or original welfare regime, either in theory or in practice. The idea of wrapping a welfare state around a society as big and complex as the Chinese one is audacious. For a developing country, there is no question that what has been achieved in a short time towards the realization of that vision is substantial and impressive. However, what is being achieved is coming late in the development process and is being

achieved only very hesitantly. The welfare state that is emerging in China is one without novelty and is guided by no other idea of purpose than to be a support system for the market economy. It is not, and is not seen to be, an instrument in the transformation of a brute market economy into a qualitatively different socialist market economy. In the universe of welfare state experiences, including that of East Asian developmental welfarism, the welfare state in China is limited and defensive in both ambition and practice.

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9

China's Universal Health Care Coverage

William Hsiao, Mingqiang Li and Shufang Zhang

Introduction

Despite being a developing country with approximately 1.4 billion people, China has managed to extend a basic health care safety net to more than 95 percent of its population over the past decade.[1] What forces converged to make this achievement possible? Guided by the political economy theory on agenda setting developed by John Kingdon (1984), this chapter illustrates that achieving universal health coverage (UHC) in China has required the convergence of the following factors: heightened problem recognition, ideas/ideology for policy formulation, political institution willingness and available fiscal space. We also demonstrate, however, that official universal health insurance coverage in contemporary China has not yet equated to fully comprehensive and effective coverage in practice,

[1] See discussion and sources in Yip et al. (2012).

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as not every citizen has equal access to the same quality of health care. The success of China's UHC was built on the simultaneous investment in, and development of, preventive and basic health services and the provision of insurance coverage for all. Still, stark health disparities between urban and rural residents remain, along with high health expenditures and inflation of health care costs caused by inefficiency and waste. Nevertheless, China's policy journey still provides a valuable example to inform other nations as to what is needed to enable major health system reforms.

This chapter begins with a review of the historical development of the Chinese health care system during the Maoist era, tracing its degradation during the 1980s policy shift towards privatization and commercialization. Drawing on Kingdon's (1984) multiple streams theory on agenda setting, we next analyse the political economy factors that shaped the subsequent health reform towards the establishment of UHC in 2009. We then present the current financing structure of the UHC (comprising three different insurance schemes, their benefit packages and key companion programmes designed to ensure the supply of basic services). Drawing primarily on quantitative evidence, we summarize the impact of China's UHC in terms of access to health care, quality and affordability of health care, equity in access and quality, health outcomes and financial risk protection to households affected by exorbitant medical expenses. We conclude with a discussion of the remaining challenges for China's health care system and comment on the possibility of learning from China's experiences.

Background: A Recent History of China's Health Care System, 1950–2009

After the Chinese Communist Party came to power in 1949, it created a national health care system that was typical of communist states. The private practice of medicine and the private ownership of health facilities disappeared during the nationalization movement in the 1950s—the funding and running of all hospitals and health care facilities became the responsibility of the government.

In rural areas, the commune provided health services to its members through the Cooperative Medical System (CMS), which operated rural

health posts run by community health workers with minimal training—the so-called village "barefoot doctors". Township health centres provided a more comprehensive range of services to all commune residents with average populations of 10,000.[2] The CMS was funded from three separate sources: the commune, the government and patient payments.

In urban areas, residents relied on their employers—the state enterprises—to organize and finance clinics and hospitals, which provided health care for workers and their family members. Those unaffiliated with a state enterprise relied on public neighbourhood health clinics and public hospitals for health services, both financed largely by the local government.

From the early 1950s to the early 1980s, the state-run Chinese health care system made enormous improvements in the delivery of public health and primary care, particularly in controlling infectious diseases through immunization, disease vector management and sanitation improvement (Hesketh and Wei 1997). Infant mortality fell from 200 to 34 per 1000 live births, and life expectancy increased from about 45 to 68 years (UNDESA 2012).

Unfortunately, this extraordinary trajectory was curtailed when China embarked on economic reform based on privatization and marketization in 1978. Under the strong influence of 1980s neoliberalism (Blumenthal and Hsiao 2005; Birch and Mykhnenko 2010), this reform led to four drastic changes in Chinese health policy: it shifted public financing to private sources; it turned public hospitals and clinics into commercial, for-profit enterprises; it decentralized China's health system; and it altered the price structure for public facilities, thereby enabling profit making.

The first policy change involved a shift from public to private financing of health care. When China's socialist economy changed to a market economy, the government experienced a drastic reduction in revenue from tax and earnings of state-run enterprises, which fell from 30 to 10 percent of gross domestic product (GDP). Consequently, by the early 1990s, subsidies for public health facilities fell from 50–60 percent to merely 10 percent of the facilities' total income (Yip and Hsiao 2008). The government, therefore, replaced public funding with private sources. In urban areas, the Employee Medical Insurance (EMI), a health insurance programme for government employees and employees of state enterprises, was reformed. This largely preserved the current health care

[2] See discussion in Zhu et al. (1989).

system for urban workers in the formal sector; however, migrant workers and urban residents working in the informal sector were left uninsured. In rural areas, the government had completely dismantled the communes to privatize the agricultural economy, which destroyed the commune-based health care safety net for rural residents. Without the CMS, 900 million rural, mostly poor citizens became uninsured overnight. In the meantime, the celebrated "barefoot doctors" became unemployed and were forced to privatize their services.

The second policy change was that the Chinese government forced public health clinics and hospitals to rely on patient fees as their main source of income, rather than introducing insurance schemes to substitute for the reduction in government financing. This turned public facilities into for-profit enterprises. Selling drugs and performing tests were the most lucrative ways to stay afloat, pay bonuses to staff and generate funds for expansion, thus by the mid-1990s, drug sales and test orders skyrocketed.

The third policy change involved decentralizing control of the public health system by transferring responsibility for local public health systems to local governments in order to reduce the central government's funding burden. Rich provinces had some resources to partially cover these costs, but poor ones did not, creating significant disparities across provinces and counties. Public health agencies were granted authority to charge a fee for curative services. Predictably, local public health authorities concentrated their activities on revenue generation and neglected preventive programmes such as health education, maternal and child health and epidemic control.

The last major policy change involved pricing. The Chinese government wanted service prices to be affordable to patients but also wanted public facilities to survive and flourish. With a lack of adequate understanding that an ill-designed payment system would lead to undesirable behaviour by health care providers and consequently to inefficiency, the Chinese government promulgated an unsound pricing policy that set in motion significant changes in the organizational culture, motivation and behaviour of hospital directors and practitioners. For instance, the government demanded that labour-intensive services such as physician visits or daily hospital bed charges remained below cost, while setting prices for new and high-tech diagnostic services above cost. They also allowed

a 15 percent profit margin on drugs. Consequently, providers pursued revenues by overprescribing drugs and tests and racing to adopt high-tech services. These medical practices not only caused rapid health expenditure inflation, but also harmed patients with adverse reactions from the overuse of drugs, drug toxicity, false positive results from poorly executed tests and unnecessary hospitalizations (Liu and Mills 1999; Reynolds and McKee 2011).

The unfortunate consequences of this combination of policy changes are best understood from three perspectives: disparities between rural and urban residents, the poor quality of health care and rising health expenditure rates. For instance, in 2003, child mortality rates were 33 per 1000 in rural areas, but only 15 in urban locales. Maternal mortality rates were 65 and 28 per 100,000, respectively, in rural and urban areas in 2002—a more than twofold gap (PRC MoH various years). As for the quality of care, the inappropriate use of prescription drugs provides an indicator. Data show that 50–75 percent of patients suffering from the common cold in China were prescribed antibiotics, more than double the international average of 30 percent (Cheng 2005; Li et al. 2012). Regarding health cost inflation, between 1978 and 2011, personal health spending per capita in China increased from RMB 11 to RMB 1,801(roughly USD 6 to USD 280), representing a 164-fold increase. By contrast, the Consumer Price Index increased by only 5.65 times over the same period (NBS various years). A huge portion of this expenditure was for high-tech tests and unnecessary drugs; about half of Chinese health care spending during this time was devoted to drugs, compared to only 10 percent in the United States (Chen 2005; Hsiao 2014).

Converging Streams of Forces Drive Universal Health Coverage

Although Chinese people experienced serious problems regarding access to affordable and reasonable quality health care throughout the 1980s and 1990s, the situation did not give rise to policy changes. China did not replace the social welfare system for rural residents for 25 years, until 2003,

while a new social health insurance system was developed only for governmental and state enterprise employees by the mid-1990s. So what forces led China to introduce and implement major health reforms in 2009?

In order to explain how the 2009 health reform came about, we adopt John Kingdon's theory on agenda setting to symmetrically capture the complex set of contributing factors that led to this reform. According to Kingdon (1984), three critical forces, described as "streams", have to converge to establish policy reform: the *problem* stream, the *policy* stream and the *politics* stream. The problem stream forces policy makers to recognize the importance of a problem and give it priority. The policy stream is the process by which policy proposals are generated, debated, revised and put forth for serious consideration. The politics stream refers to political factors that influence agendas, such as changes in elected officials, political climate or mood, and the voices of advocacy or opposition groups. Kingdon argues that the three streams are relatively independent and have "lives" of their own. However, we modified Kingdon's framework in order to show that in the Chinese context, these three streams interact significantly, rather than being independent. Moreover, we added another critical stream: fiscal capacity—a factor that Kingdon subsumed under the policy stream. We argue that Kingdon's theory addresses reforms in general, rather than specific major programmes that require significant additional government spending. When a nation reforms its social safety net, fiscal capacity is also a critical factor.

Kingdon's theory has been used extensively to analyse the policy changes that occur in developed countries under a democratic regime. China, however, has a highly centralized and authoritarian government controlled by the Chinese Communist Party (CCP), which will be taken into account when applying Kingdon's theory. In this system, high-level political leaders can unilaterally make decisions regarding health reform, although since economic reform began in 1978, the Chinese political system has evolved beyond the traditional definition of authoritarianism (Linz 1964). It is now permeated with a wide variety of participatory and deliberative practices—including the participation of academics, domestic and foreign interest groups, international organizations and foreign advisors—in its problem identification and design of policy options (Kornreich et al. 2012; Korolev 2014).

The Problem Stream: Recognizing the Problems and Diagnosing Their Root Causes

The problem stream has two stages. First, political leaders and the general public must recognize the existence of a serious problem. Second, under ideal circumstances, the root causes of the problem can be accurately diagnosed.

We have explained that after China's 1978 economic reform, Chinese patients had increasing difficulty accessing affordable health care of reasonable quality. These problems first became noticeable in the late 1980s; as they became more widespread, reports of health care problems emerged in the media, academics conducted studies to document the foremost problems and negative public opinion began to grow. This eventually resulted in the advent of the popular 1990s lament of "*kanbingnan, kanbinggui*" or "insurmountable access barriers to health care, insurmountably high health costs". This widespread discontent was publicized on Chinese television, in the press and on the Internet, and it soon attracted the attention of China's political leaders (Eggleston 2010).

During the 1990s, both domestic and foreign scholars, as well as international organizations, were persistent and timely in diagnosing the problems of the Chinese health sector. However, while the Chinese government focused on economic reform, problems in the social sector were seen as distractions or embarrassments and were often neglected. For instance, Chinese political leaders at the time did not believe impoverishment could be caused by medical expenses, despite evidence, which was dismissed as isolated incidents in selected poor regions (Liu et al. 2003). It was not until a 1993–1995 Harvard/UNICEF study gathered evidence on the impact of health care costs across China that the government was finally convinced of the link between health expenses and impoverishment (World Bank 1996). This empirical, nationwide study led top political leaders to organize the first Chinese National Health Conference in 1996, where President Jiang Zemin called for government programmes to alleviate poverty generated by medical expenses as part of China's anti-poverty programme. However, the recognition of the problem was not matched by political action as there was little additional

funding for policy implementation. The Ministry of Finance (MoF) argued that China did not have the fiscal resources to finance a national health insurance programme and only allocated funding for several pilot studies and the basic infrastructure of township health centres in low-income regions.[3]

The severe acute respiratory syndrome (SARS) epidemic in 2003 marked a new era for the recognition of health system problems, as well as of their root causes. A 2004 article by prominent political scientist Shaoguang Wang (2004) argued that SARS was not an isolated incident, given China's weak health care system caused by decades of dysfunctional health policy. This view was shared by Chinese intellectuals, especially progressives ones. At the same time, the World Bank sponsored a study conducted by the Development Research Centre of the State Council (DRC), led by Yanfeng Ge, which conducted a critical analysis of China's health system. The report concluded that Chinese health policy since the mid-1980s had been a failure (Ge and Gong 2007). It highlighted inequities in both access to and quality of health services, as well as inefficiencies in the health system besides impoverishment of households caused by medical expenses. While these problems were already well known among health officials, the DRC report gave legitimacy to previous findings due to DRC's influence as the think tank for the State Council. The DRC report concluded that China's health care problems were caused by government policy adopted in the mid-1980s, which relied on private financing and allowed health care delivery to be driven by market forces.

The major findings of the DRC report were published in a popular newspaper, leading to a firestorm of public debate (Wang 2005). The Ministry of Health (MoH) tried to defend itself but was nonetheless held responsible for the poor performance of the health system. Thus, by identifying the root causes, the DRC study served as a cornerstone for the government to design new policies to remedy China's health care problems. In 2006, Premier Wen Jiabao included the "*kanbingnan, kanbinggui*" problem in his Government Work Report (Xinha News Agency 2006). The government committed itself to solving these issues without further delay.

[3] Hu (1995), Cao (2009), Bloom (2011).

The Policy Stream: The Ideological Debate and the Policies that Emerged from It

The policy stream is a process whereby major stakeholders identify problems and propose different policy options for debate. Kingdon argued that there are "policy entrepreneurs" (for example, elected officials, civil servants, lobbyists, academics and journalists) who play an important role in this process. However, the authoritarian nature of the political regime in China left limited space for such "entrepreneurs" to play a direct role in the way they are able to in a democratic system. Because Chinese political and bureaucratic ideology directly shapes the direction of reform and its associated policies, a central task for policy entrepreneurs in China is to influence the dominant ideology.

The principal ideological issue involved in China's health reforms, including the most recent that led to UHC, centres on the relative roles of market and government in health financing and the provision of health care (Wang and Fan 2013; Zhang 2013). This debate began in the early 1980s when China started its economic reform and transformed from a planned to a market economy. While the Chinese health system originated with a communist ideology, which calls for the government to play a central role in financing and providing health services, many Chinese political leaders and bureaucrats embraced the pro-market ideology, especially under the pressure of dramatically reduced fiscal revenue (Qian 2000). The flurry of health providers' profit-driven activities in the medical market led to a debate inside the MoH in the early 1990s about whether the market should take the leading role in providing health services, which caused concern among some Chinese political leaders (Zhong 2011). However, the debate became quiet after leaders and experts recognized that the government simply did not have the financial resources to fund health care anymore.

Meanwhile, Chinese academics and health policy analysts gradually began to question the ideology of the market in the health sector, influenced significantly by a group of experts in health policy and economics since 1985. With substantial attention and evidence from both international and domestic experts, China's leaders became increasingly aware of the pressing issues of the national health care system. However local government leaders were far slower to acknowledge the issues of market failure in health care

and take subsequent action (Word Bank 1996). An extreme example can be drawn from Suqian City in the Jiangsu province, which adopted "complete marketization" from 1999. The top city officials sold all public hospitals to private investors in order to unload their heavy fiscal burden (Tam 2010).

The 2003 SARS crisis served as the greatest catalyst for a wide range of reflections on the ideology of market-driven financing and provision of health care. Several major articles and reports pointed at the marketization and privatization of health care as the culprit behind the weak health system and consequent public health crisis (Wang 2004; Huang 2004). Thus, the heated debate between intellectuals about the relative roles of market and government in the health sector intensified, dividing intellectuals into pro-market versus pro-government camps fighting to defend theories and justify ideologies.

The major difference of opinion lay in the delivery of hospital services. The pro-government camp argued that the government must rely on a large network of public hospitals to provide effective services for everyone. By contrast, the pro-market camp called for a privatized hospital system in which the government would only play a purchaser role under a social insurance system, arguing that privatized hospitals would produce higher quality and more efficient services than public hospitals. To date, this debate remains unsettled, with each camp "cherry-picking" evidence from domestic and international experiences to support each respective argument. The debate was given the apt label of "the battle of models" by the Chinese media (Bai 2006).

A major breakthrough that partially resolved the debate was President Hu Jintao's presentation of his regime's ideological campaign for a harmonious socialist society in 2005 (Zhong 2006). The campaign represented a shift in ideology and stated that the government had a responsibility to provide citizens with a social safety net, lending support to the pro-government camp regarding funding sources for UHC (Hsiao 2007).

The Financial Stream: Available Fiscal Space

Achieving UHC requires substantial financial resources. Over the last ten years China established universal health insurance coverage by subsidizing people's premiums while also investing in primary care facilities and human resources. All of these programmes require significant additional public spending.

In the early 1980s, China's health policy was shaped by fiscal constraints. As in all other former socialist nations that shifted from a planned socialist economy to a market economy, government revenue dropped sharply from 34 percent of GDP in 1978 to 11 percent of GDP in 1994 (as shown in Fig. 9.1) (Yip and Hsiao 2008). Consequently, the government's capacity to finance programmes declined.[4] Then, in 1994, China reformed its taxation and public finance system, and government revenues have been increasing steadily ever since. From 2001 to 2011, government revenues increased dramatically—by more than 20 percent per year on average (NBS various years). Fiscal constraints were thus not a major consideration when health reform was debated in 2006–2008, although the MoF did question the absorptive capacity of the health system to use large amounts of the new funds efficiently and effectively.

During the past 15 years, the revenues of the Chinese government have increased phenomenally, "from USD 113 billion in 1995 to USD 1.86 trillion in 2012", measured in 2012-constant USD (Naughton 2014: 16). In contrast to the situation in the 1980s, when the government lacked

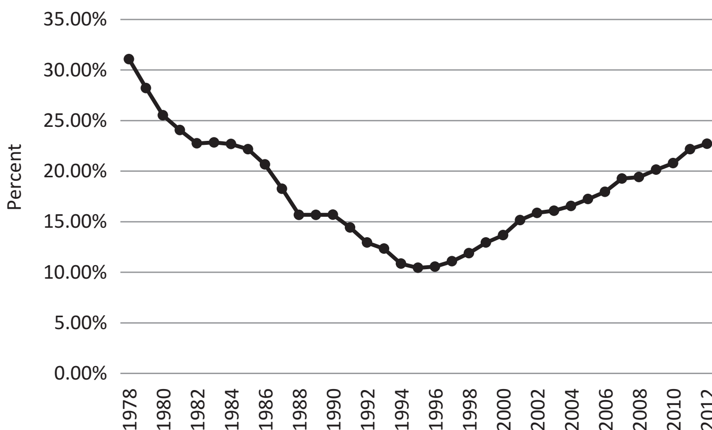

Fig. 9.1 Chinese government revenue as a percentage of GDP, 1978–2012 (*Source*: Author based on data from NBS (various years))

[4] In nominal absolute RMB, government revenue actually increased, but inflation and government employee wage increases vastly outpaced revenue growth.

the funds to finance public health services and decided to turn to private financing, now the government has the revenue stream to fund an entire social safety net. An additional RMB 800 billion (USD 125 billion) was allocated over three years (2009–2011) for health, which only amounted to roughly 20 percent of the increased revenues received by the government during that period (Yip et al. 2012).

The Politics Stream: Setting Priorities and Formulating Policy

The last stream in Kingdon's framework is the politics stream, which refers to political factors that influence agenda setting and policy formulation. In China, the politics stream is entangled with other streams, as discussed above. Nevertheless, its distinct outline is still discernible.

In the post-SARS era, a portion of the Chinese population rapidly gained wealth. However, the majority have not enjoyed the same rate of rising income, resulting in alarming economic, social and health disparities. Chinese leaders have been sensitive to public dissatisfaction and social unrest over these inequalities and have responded accordingly (Hsiao 2007).

In 2004, for instance, the CCP promulgated the "Scientific Development Perspective" as one of the guiding socioeconomic principles, which highlighted the importance of social safety nets and paved the way for health system reform (Holbig 2009). China began a national campaign that shifted the focus of the development agenda from "economic growth" to "social harmony". As part of this shift towards more egalitarian and populist policies, equal health opportunities, or "improving people's livelihood" across the population became a new primary focus. With this foundation laid, the political priorities of the four respective streams aligned, thus enabling reform of China's health system and a move towards achieving UHC. The Politburo even held a session to study and discuss health sector reform in 2006. In that session, President Hu stated that the goal of health reform was "providing basic health care for everyone". At this meeting, several guiding principles were put forward, such as the "People's health is the responsibility of the CCP and the government" and "Health services should serve public interests" (Li 2011).

In June 2006, the government's new commitment to health sector reform established a powerful Inter-Ministry Task Force to design and launch health sector reform, led by the Minister of the National Development and Reform Commission and the Minister of Health. Participating ministries included the MoF, the Ministry of Labour and Social Security, the Ministry of Commerce and the National Federation of Labour. The initial count of 14 ministries was eventually expanded to include 20 ministries and agencies. Such an extensive collaboration between ministries and agencies for dealing with non-economic issues was extremely rare, and served as evidence of the importance placed on this issue by the government (Wang and Fan 2013).

The Task Force initially established four separate teams, each responsible for different components of the reform and managed independently by a major stakeholder: the MoH, MoF, Ministry of Human Resource and Social Security, and the National Development and Reform Commission. By the end of 2006, however, the Task Force found it impossible to obtain consensus among its members on priority setting or an integrated reform plan.

The Task Force therefore commissioned seven domestic and international non-governmental organizations to develop alternative health sector reform proposals. A high-level conference including the heads of 20 Chinese ministries and agencies was held in mid-2007 to present and deliberate on the issues. The proposals, however, reflected the ideological divide in China between government and market approaches to health care. They differed vastly on the roles given to government and the market in the financing and delivery of health care, as well as on the degree of regulation needed for domestic and foreign pharmaceutical and medical devices.

After realizing that no consensus between the opposing ideological approaches could be reached, the co-chair of the Task Force asked William Hsiao (first author of the present chapter) to organize a group of six international experts, not associated with any of the seven proposals, to offer broad policy guidelines that they could agree upon. Hsiao's group of six experts relied on economic theory and worldwide evidence and produced five principal guidelines. One important guideline stated that if China wanted to give priority to equitable health care, then the government must play a major role in financing public services, rather than

relying on private funding such as out-of-pocket spending and private health insurance. Other guidelines involved governing public hospitals to pursue public interests, shifting resources to preventive care and correcting the pricing system.[5] The guidelines were subsequently submitted to the national leaders through the Task Force.

A few months after the conference, the Task Force drafted a policy proposal guided by the international expert group's guidelines. The ministries were finally able to reach a compromise on the direction and specific features of the reform. The Task Force made its proposal public and solicited public comments before preparing the final version. It took almost two years to finalize the policy.

In April 2009, the Chinese central government announced the new policy, stating that the goal of the health reform was to establish a universal health care system that would provide safe, efficient and affordable basic health care services for all Chinese residents by 2020 (Chen 2009). The reform had three phases: the initial three years of implementation from 2009 to 2011, then 2011 to 2015 and, finally, 2016 to 2020. At the same time a detailed implementation plan with specific actions to be taken in the first three years was announced.

The Policy Outcome: The 2009 Health System Reform Towards Universal Health Coverage

The first three-year implementation plan was anchored by five specific targets: (i) expanding insurance coverage; (ii) making public health services available and equal for all; (iii) improving the primary care delivery system to provide basic health care; (iv) establishing a national essential drug system; and (v) piloting public hospital reforms. In this section, we explain the content of the reforms, progress towards these reforms and the gaps that remain in these five areas (Li 2011; Yip et al. 2012).

The Chinese government originally committed RMB 800 billion (USD 125 billion) of additional public spending for the first three years of health care reform; however, the government boosted this amount, spending

[5] Hsiao, William. Personal interview, 8 October 2014.

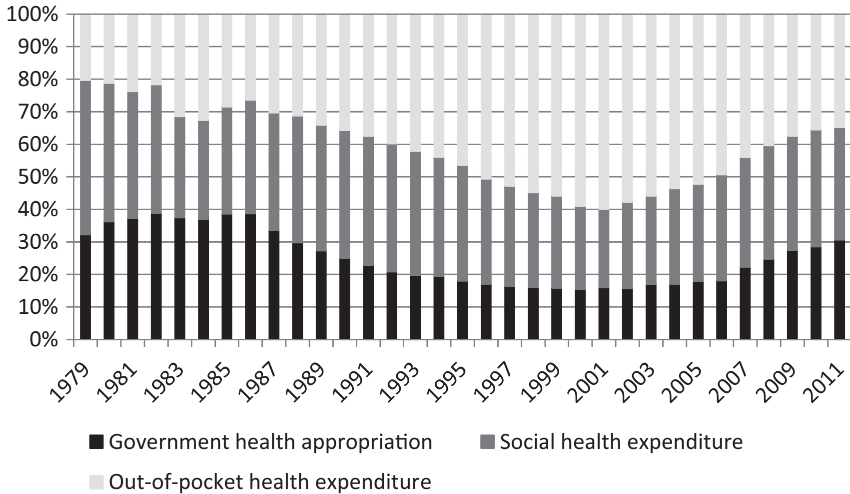

Fig. 9.2 Total health expenditure composition in China, 1979–2011 (*Source*: Author based on data from PRC MoH (various years)).

a total of RMB 1.5 trillion (USD 235 billion). This dramatically increased the share of government expenditure as a percentage of the total health expenditure from 18 percent in 2006 to 30 percent in 2011. About half of this amount was allocated to subsidize premiums for enrolment in insurance schemes, a third was used to strengthen the primary care delivery system (especially infrastructure building and personnel training in rural primary health care facilities), and the rest paid the recurrent expenses of basic public health services (Thompson 2009; Yip et al. 2012). Figure 9.2 shows the changes in public share of total health expenditures.

Universal Insurance Coverage

Prior to the 2009 health reform, China had launched three insurance programmes: EMI, established in 1998, which covers employees in the formal sector; the New Cooperative Medical Scheme (NCMS) for rural residents, which was introduced in 2003; and Urban Resident Basic Medical Insurance (URBMI) for urban residents not employed in the formal sector, launched in 2007.

To achieve the goal of expanding insurance coverage to over 90 percent of its population during the first three years of the reform, the Chinese government adopted a strategy to subsidize most of the insurance premiums for rural and urban residents who were not eligible for EMI. The government subsidized approximately 90 percent of the premium for rural residents in poor western regions and approximately 70 percent for rural residents in wealthier coastal provinces. In addition, central government set enrolment target as a performance criteria to evaluate local leaders. As a result, insurance coverage levels grew rapidly. In 2000, only 15 percent of the Chinese people had insurance coverage, mostly through EMI. By 2012, more than 95 percent of the Chinese population was covered by one of these three insurance schemes (Yip et al. 2012).

Table 9.1 compares different aspects of the three insurance programmes. As of 2012, both NCMS and URBMI beneficiaries still had to bear about 50 percent of their inpatient and outpatient costs, taking into account deductibles, co-payments and reimbursement ceilings. Thus, the disparity in the benefit package between EMI and the other two programmes remained significant. Since 2012, the government has allocated funds to subsidize premiums and expand benefit packages, particularly to cover catastrophic medical expenses.

Prioritizing Prevention

The health reform made preventive health care a priority. In 2009, the government provided RMB 25 (USD 4) annually per resident to be paid to primary care practitioners (that is, village doctors, physicians in township health centres, and urban community health centres who are responsible for public health). Primary care practitioners performed 41 specific public health duties such as immunization, prenatal and child care, and maintaining health records for patients with hypertensive and diabetic conditions. However, China still lacks a monitoring system to evaluate the performance of these primary care practitioners and establish a payment system based on performance.

Table 9.1 Summary of the three social health insurance programmes

	EMI		URBMI		NCMS	
Year	2008	2012	2008	2012	2008	2012
Target population	Formal sector workers		Children, students, elderly without previous employment, informal sector urban workers and some migrant workers		Rural residents	
Risk-pooling unit	City	City	City	City	County	County
Enrolment	81 %	94 %	64 %	93 %	91.5 %	98 %
Total premium per person (RMB)	1443	2230	120	300	120	300
Government subsidy per person (RMB)	None	None	80	240	80	240
Individual contribution	2–3 % of salary	2–3 % of salary	40	60	40	60
Employer contribution	6–8 % of salary	6–8 % of salary	NA	NA	NA	NA
Benefit design						
Inpatient reimbursement rate	67 %	75 %	44 %	55 %	38 %	55 %
Outpatient reimbursement rate	Individual savings accounts	Individual savings accounts	NA	50 %	NA	50 %
Total reimbursing ceiling	Four times average wage of employee in the city	Six times average wage of employee in the city	NA	Six times disposable income of local urban residents	NA	Eight times income of local farmers

Source: Adapted from Yip et al. (2012).

Public Investment in Basic Public Health Services

Another major component of achieving UHC was to invest in the primary care system. China's long-term strategy to improve efficiency in allocating health resources involved building a delivery system based on strong preventive and primary health care anchored in community health centres in cities, and township health centres in rural areas. To meet these goals, the government earmarked funds for building primary care facilities and electronic information systems, as well as staffing these facilities with qualified practitioners and primary care physicians. The 2009 health reforms allocated RMB 60 billion (USD 9.4 billion) to establish or renew primary care facilities, mostly in under-serviced rural areas of western China.

Despite these interventions, China relies on village doctors and medical school graduates with only three years of medical school training to deliver basic primary care health services. Chinese patients often lack confidence in the competency of these primary care providers and when patients need medical care of high quality, they often rush to specialists in hospitals (Eggleston et al. 2008). China is currently giving priority to training graduates of five-year medical schools as family physicians—a significant improvement over their current level of training.

Production, Pricing and Distribution of Essential Drugs

As mentioned earlier, the fact that Chinese hospitals received a portion of their profits from selling drugs had led to a system of "pharmacy-subsidized health care", causing a great increase in overall drug spending in China. The 2009 reform established the "essential medicine system" in order to improve this situation by better regulating pharmaceutical supply chains and reducing the overall cost of drugs. The central government published a catalogue of 307 types of basic medicines, although most provinces added supplementary lists (Yip et al. 2012). The government requires all primary care institutions to use only these essential drugs and sell them to patients at cost. The government also created a bidding platform for the procurement of essential drugs for primary care facilities.

The essential medicine system is controversial. While drugs on the list are selected by physicians and pharmacists organized by the MoH, the selection is not necessarily based on rigorous scientific criteria. Furthermore, the selection process is quite opaque and serious questions have been raised about the selection criteria and the adequacy of the essential drug list in promoting the use of cost-effective medications (Yang et al. 2012). The "selling at cost" policy may also lead primary care providers to underuse these essential drugs.

Public Hospital Reform

Although public hospital reform was listed as a goal in the initial three-year health reform plan, there were no concrete guidelines from the central government on how to carry out these reforms. The central government selected 17 cities to experiment with different approaches in reforming public hospitals. However, without clear guidelines, some pilot cities focused only on minor changes, such as the registration of visits by phone, while others made major changes for the governance structure of public hospitals. Some cities even experimented by selling their public hospitals to private investors or hospital workers' collectives. Unfortunately, these experiments did not produce many useful results or scientific evidence to guide national policy. The experiments had cursory designs and did not evaluate their impacts rigorously. Moreover, none of the pilot cities seemed to be able to significantly change the organizational behaviour of their hospitals. This echoed the unsettled "battle of the models" between the market camp and the government camp from initial deliberations over the 2009 reform.

Achievements and Remaining Challenges

Despite the remaining problems outlined above, China's health care reforms have enabled the country to achieve a 95 percent rate of insurance coverage by the end of 2011, and made preventive and primary

care available to almost everyone.[6] As noted earlier, however, significant disparities in the quality and accessibility of primary and hospital care remain between rich and poor, urban and rural populations. We conclude, therefore, that China has not achieved universal access to an equal quality of health services. Our final section presents the existing evidence on the impact of China's UHC on equitable access to basic health care, including its quality and affordability. We also examine cost control to ascertain the sustainability of the system.

Health Equality: Access, Affordability, Risk Protection and Health Outcomes

The immense insurance coverage increase from 15 percent in 2000 to 95 percent in 2012—covering 1.28 billion people—represents the most significant achievement of health reform in China to date. This fact undoubtedly improved health equity as well as the affordability of health care.

Better access to health services has indeed been reported as a result of the reform. The analyses of the National Health Services Survey of 2003, 2008 and 2011 show that physical access to health facilities improved considerably, especially in rural western and central regions.[7] Antenatal care coverage and hospital delivery rates increased dramatically between 2003 and 2011 nationwide, with the largest increase again occurring in rural, western and central regions of China (PRC MoH various years).

The shallow benefit packages of the health insurance programmes have been gradually increased (Yip et al. 2012). However, specific benefits and reimbursement rates vary across the three major health insurance schemes, as shown in Table 9.1. These differences suggest dissimilar insurance benefits as well as different affordability of health services between rural and urban residents, between different socioeconomic groups, and between formal sector employees and others. According to the reform plan, China aims to merge the three packages into one over

[6] This number is confirmed by independent studies such as Yip et al. (2012).

[7] See discussion and resources in Meng et al. (2012).

the next decade to eventually remove the inherent inequality associated with these three insurance schemes.

High rates of health insurance coverage may enable health reform to offer more affordable health care; however, the evidence on this front is mixed. When an effect is found, it varies across regions and population groups. According to Meng et al. (2012), there was a 5 percent annual reduction in self-discharges from hospitals in 2008–2011, with western regions showing the highest annual reduction of about 8 percent, suggesting the improved affordability of health care. In addition, the percentage of households experiencing catastrophic health expenditures decreased annually by 2.6 percent between 2008 and 2011; the rate had previously increased by 2.8 percent annually between 2003 and 2008, prior to full implementation of the major reforms. The biggest decrease occurred in rural and western China, with annual reductions of 3.0 and 4.7 percent from 2008 to 2011. Nevertheless, Meng et al.'s (2012) study also shows a disparity between the poorest and the richest quintile, with poorer households experiencing catastrophic health expenses twice as often as their richer counterparts between 2003 and 2011.[8]

Little evidence exists on the health outcomes of patients affected by UHC,[9] yet it is reasonable to speculate that they would improve. For example, the dramatic increases in antenatal care coverage and hospital deliveries, supported by government subsidies and insurance coverage, would arguably lead to improvements in infant and maternal mortality, especially in rural areas. However, inequity in health outcomes between urban and rural residents remains a major problem for China. Table 9.2 shows the differences in the health status of these two groups over five years (2006–2010).

[8] As suggested by Yip et al. (2012). NCMS, though it has increased health service utilization to varying degrees as reported by different studies, does not show a "measurable effect on the reduction of financial risk". Few studies have been carried out to assess the financial protection effect of URBMI. One study shows that the out-of-pocket payment for hospitalization for URBMI enrolees was about 26 percent lower than uninsured urban residents, suggesting some degree of financial protection with URBMI (Liu and Zhao 2012).

[9] The lack of evidence for health outcome improvements may be further explained by the fact that the reforms are rather recent and enough time has not passed to observe their effects. More importantly, the general lack of reliable national data for China that can support a thorough analysis based on rigorous assessment presents another challenge to assessing the health outcomes of system reform. Last but not least, the many moving parts of this complex reform, and significant variations in local governments' capacities to implement the reform policies, certainly make assessment at the national level challenging.

Table 9.2 Comparison of health status between rural and urban residents, 2006–2010

	National	Urban	Rural	Ratio (urban to rural)
IMR (per 1000 live births)	14.86	6.84	17.96	1:2.62
MMR (per 10,000 births)	34.76	27.1	37.4	1:1.38
Life expectancy	74.83	77.33	72.29	1.07:1

Sources: Infant mortality rate (IMR) and maternal mortality rate (MMR) are calculated by averaging the five-year period; data are from NBS (various years). National life expectancy is from the 2010 Census, and rural and urban life expectancy are extrapolated using the existing data before the 2010 Census (Hu 2010).

A major cause of inequity in health status between rural and urban residents is the distribution of human resources. Like most nations, China has difficulty attracting and retaining well-trained physicians to rural towns and small cities, with highly trained physicians and specialists usually preferring large cities. The difference in insurance benefits among the three insurance plans shown in Table 9.1 further contributes to the rural–urban inequity.

Quality of Care

To improve the quality of care is a critical goal of China's health reform, and providing everyone equal access to the same quality of affordable health care is an ultimate measure of the success of UHC. There is insufficient evidence to make any conclusions about the impact of the Chinese health system reform on the quality of health care, though it is likely that the quality of care will improve as the health system reform deepens (Hsiao 2014).

Cost Control

China faces a major challenge that its health reform has not yet been able to solve: how to alter the behaviour of its public hospitals and physicians so that they serve the interests of the people, and ultimately curb the increases in health care costs attributable to health providers' profit-driven behaviours, such as overhospitalizing patients, overprescribing drugs, overtesting and

using the most expensive drugs when lower-cost generics are available. Past efforts to transform public hospitals and physicians so that they serve the public interest have largely failed. The political economy of this situation shows that the interests of powerful stakeholders can block government attempts to reform public hospitals and curb their abuses (Wang and Fan 2013).

As the social health insurance programmes expand, China is confronting high rates of health expenditure inflation due to the lack of control of providers' misbehaviour. While China has experienced remarkable growth in per capita GDP, it has been outpaced by growth in per capita health expenditure: national health expenditure as a percentage of GDP rose from 4.0 percent in 1990 to 5.2 percent in 2011, as seen in Fig. 9.3. As the Chinese economy reaches the upper middle-income level, its growth is expected to slow down, and there is a serious question as to whether UHC can be sustained without slowing the inflation rate on health expenditure.

While China spent a relatively high percentage of GDP on health compared to India's 3.9 percent (in 2011), it spent relatively less than upper-middle-income nations such as Mexico (6.2 percent) and

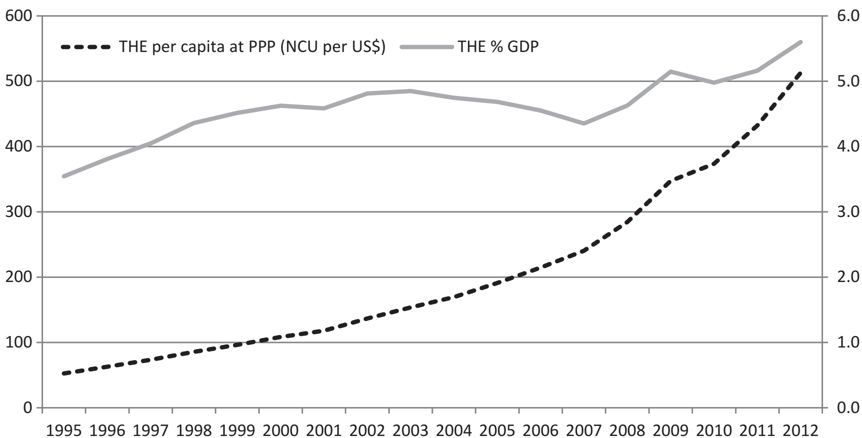

Fig. 9.3 Total health expenditure per capita and total health expenditure as percentage of GDP in China, 1995–2012. *Note*: *THE* total health expenditure, *PPP* purchasing power parity (*Source*: Author based on data from PRC MoH (various years))

Brazil (8.9 percent).[10] Still, Chinese spending will likely continue to grow at a rapid pace as its population ages. How to effectively control health expenditure inflation remains a key challenge in China's health system reform and the sustainability of its UHC.

Conclusion and Comments

China has rapidly achieved UHC, covering prevention, primary care and comprehensive curative services. Indeed, China may be the first large, middle-income nation with a population over 100 million that has attained effective UHC. Achieving universal coverage even for basic health care takes strong political forces and financial resources.

In this chapter, we analysed the Chinese health care system reforms with an adaptation of John Kingdon's theory, which maintains that reforms require the convergence of four streams: problem recognition, political space created by catalytic moments, innovative policy ideas and fiscal space. We offered a historical analysis of the complex process wherein these streams have developed and converged slowly between the mid-1990s and the mid-2000s. Using Kingdon's theory moved us beyond typical analytical frameworks that rely on political analysis only.

The Chinese case also highlights several valuable lessons. One is that in achieving effective and high-quality UHC, nations have to go beyond merely providing insurance coverage. A supply of high-quality health services must also be available throughout the country, and people must be able to afford these services. Insurance coverage only requires the government's decision to fund and adequately subsidize insurance premiums; transforming this funding into effective and high-quality health care may require reforming the current health care delivery system, altering the organization and management of health organizations, reforming payment/incentive mechanisms, assuring the quality of health services, establishing information systems and strengthening accountability for outcomes. Such complex changes require technical expertise and a long-term commitment to implementation.

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[10] Percentages from World Health Organization *Global Health Expenditure Database*. Accessed 14 July 2014. http://apps.who.int/nha/database

Effective health insurance coverage may also require a systemic health care delivery reform to supply quality services and drugs to the poor and underserved on an equal level with others. Often, new and sophisticated human resource policies for the health workforce have to be designed and implemented. Moreover, the structure and governance of public health services often have to be altered to improve quality and efficiency. Most developing nations, like China, suffer from inefficient health care delivery systems. The World Health Organization (WHO) estimates that, globally, a 30 percent savings could be achieved by addressing the areas of greatest inefficiency (WHO 2003). However, successful reform would require the backing of vested interest groups. China's attempt to reform its public hospitals illustrates the strong political pushback from public hospitals and their physician staff, whose income from profit-driven practices may be reduced. As a result, China is still searching for a feasible method to use in reforming its public hospitals.

Overall, this chapter shows how international ideas such as equity, neoliberalism, market forces and social health insurance have influenced China's health reforms and decision making. At the same time, ideology has also played a major role in formulating policy. Most economic analysts and decision makers believe free market ideology is the best driver of economic growth, but many blindly extend the free market ideology to the health sector without considering the consequences for equity, or the serious market failures in the health sector. Despite the adverse consequences of following a market strategy between the early 1980s and the early 2000s, the free market ideology still pervades current health policy debates in China.

Finally, the China case demonstrates the importance of medical ethics in health care. Physicians are professionals with wide discretion in diagnosing and treating diseases. In making medical decisions, a physician's professional duty to the patient can be in conflict with his or her own interests (for example, income, promotion and social status). Indeed, the Chinese system had encouraged physicians to be profit seekers at the expense of patients for over twenty years. Medical ethics guides such as the Hippocratic Oath aim to instil standards for physicians' medical practices and their professional behaviour; however, enforcement often relies on self-regulation. As China now tries to reverse course, it is discovering that once medical ethics have been eroded, restoring them is a herculean task. There is a valuable lesson here for the rest of the world.

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Part III

Obstacles to Moving Towards Universal Health Care

10

Constraints on Universal Health Care in the Russian Federation: Inequality, Informality and the Failures of Mandatory Health Insurance Reforms

Linda J. Cook

Introduction

The Russian Federation inherited from its Soviet predecessor a universal system of basic health care that was state-run and free at the point of access. The Soviet state established this system during the 1930s and 1940s as part of a process of rapid modernization and industrialization. For several decades the system produced significant improvements in key health indicators: life expectancy increased, infant mortality declined and infectious diseases were brought under control. It was reasonably effective in implementing broad public health measures and controlling communicable diseases, but could not adapt to treat more complex non-communicable conditions such as cancer and cardiovascular diseases. By the 1980s, accumulating problems of bureaucratic rigidity, low levels of medical technology, underfinancing and failed reform efforts were contributing to the

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deterioration of health conditions among Russia's population. With the collapse of the Soviet Union in 1991, Russia's statist political economy imploded, and its health care system was thrown into crisis.

During the 1990s, the health sector was buffeted by Russia's decade-long economic decline and radical efforts to transform health care provision according to a liberal, market-based insurance model. Public expenditures on health declined dramatically. President Yeltsin's poorly designed reforms introducing health care de-statization, privatization and marketization led to political conflict and disorganization that worsened dysfunction. By the late 1990s, key health indicators had declined dramatically. Famously, male life expectancy in Russia fell to below 60 years, a level not otherwise seen during peacetime in developed economies. Russia began a sustained demographic decline. From 1993 to 2005 the number of deaths exceeded births by 11.2 million, and the population was declining by about 700,000 per year (Putin 2005). While deficient health care was certainly not the only cause here, it is broadly seen as a contributing factor. Infectious diseases re-emerged and spread, and even childhood immunization programmes collapsed temporarily in parts of the Russian Federation.

The decade of crisis in the 1990s produced changes in income distribution and health care practices that became major constraints on universal access. High levels of inequality in Russian society created an "underclass" of low-income strata, especially rural populations and urban migrant workers, who have little access to medical services. Processes of "spontaneous privatization" and "shadow commercialization" within the health sector raised barriers to health care, and widespread requirements for informal payments emerged as obstacles to access.

During the decade 2000–2010 the Russian health care system recovered substantially in terms of financing, performance, organizational coherence and health outcomes. The rapid growth of Russia's economy from 2000 to 2007 provided resources to restore and increase health expenditures, while the Putin administration broadly revived the state's administrative capacities, including in the health sector. Public expenditure recovered, increasing as the economy grew, though the proportion of the growing gross domestic product (GDP) expended for health care remained modest. In mid-decade the Putin administration, responding to the demographic crisis, made health care a major policy priority.

Administration of the health care system was partially recentralized at the federal level, a pro-natalist campaign was launched and the National Priority Project on Health showcased the political elite's concerns. Older reforms, including medical insurance, were revived. These efforts produced positive results: by 2009, life expectancy had nearly recovered to its 1990 level, infant, child and maternal mortality had declined significantly, and rates of infectious diseases had stabilized (see Table 10.1). Survey evidence showed that the health care system had become more accessible, and that demands for informal payments in exchange for treatment had declined (Potapchik et al. 2011).

Serious problems remained, however, and with economic recovery a new population—hundreds of thousands of labour migrants—was added to the mix. The combination of rapid economic growth with Russia's demographic decline produced a strong demand for labour. In response, large numbers of migrants came, mainly from Central Asian and other post-Soviet states, and mainly to Russian cities. Post-2000 labour migrants are predominantly non-Slavs who enter Russia legally through a visa-free regime, then remain and work, often without formal registration. Lacking citizenship or residence permits, most are excluded from the public health care system, adding another category of constraint on universal access. The deepest inequalities inhabit this transnational space.

In sum, Russia's health care system has recovered substantially from the crisis conditions of the 1990s, has improved or at least stabilized key health indicators and has retained its constitutional commitment to citizens' universal health care rights. At the same time, the system per-

Table 10.1 Life expectancy, infant mortality, under-five mortality and maternal mortality in Russian Federation (selected years, 1990–2009)

	1990	1995	2000	2005	2009
Life expectancy at birth, female (years)	74.3	71.6	72.3	72.4	74.7
Life expectancy at birth, male (years)	63.7	58.1	59.0	58.9	62.8
Infant deaths (per 1000 live births)	17.4	18.1	15.3	11.0	8.1
Probability of dying before age five (per 1000 live births)	21.3	22.5	19.3	13.9	10.2
Maternal deaths (per 100,000 live births)	47.4	53.3	39.7	25.4	22.0

Source: Based on data from Popovich et al. (2011: 10) and Federal State Statistical Service (2010)

forms poorly in comparative international terms. Russia's public expenditure on health falls within middle-income country norms, but its level of effectiveness is low; countries spending 30–40 percent less get similar health outcomes in terms of mortality (Popovich et al. 2011: 171). Life expectancy, a key indicator of the population's health, remains low—especially for men. Infectious diseases have been stabilized, but rates of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) remain comparatively high, and Russia has very high rates of tuberculosis (TB) and multi-drug-resistant TB. Strong patterns of socioeconomic inequality—rich/poor, urban/rural and inter-regional—affect provision, as do continuing pressures for informal payments for services. High-quality private facilities are mainly limited to the elite, groups at high risk for infectious diseases are often beyond the reach of the health care system and Russia's large migrant population has very limited access to care. Overall, Russia's system of health care has become fragmented, with different population strata experiencing highly differentiated levels of access, services and quality of care.

Legacies of the Soviet-Era Health Care System

The Soviet state monopolized the health care system's financing, organization, licensing, structure, norms and practice guidelines. Private medical practices were, for the most part, banned. The system was centralized and bureaucratically managed, with the All-Union Ministry of Health at the centre and its agencies articulated down to regional and local levels. Pharmaceuticals were produced or imported and distributed exclusively by the state. Like all sectors of the Soviet economy, the health sector was planned on an input-based, extensive model—progress was measured largely by the number of practitioners educated, hospitals and polyclinics built, rural health points established; quantitative indicators mattered much more than qualitative. The well-known examples of rural "hospitals" that lacked running water epitomized the negative effects of this approach, but the larger systemic problems were an overreliance on high staffing levels, specialization, hospitalization and inpatient treatment. The World Health Organization (WHO) comparisons of Soviet (and other

communist) systems found, for example, excessively high provider–patient ratios and numbers of hospital beds by international standards. The Soviet health care system is commonly characterized as underfinanced, or financed on the "residual principle", that is, with the funds remaining after the priority areas of industry and defence had received allocations (Cook 2007). However, in comparison with Latin American and East Asian states at similar levels of development, communist states had extensive and generous systems of public health provision (Haggard and Kaufman 2008).

While access to basic health care was virtually universal, the provision of medical services was starkly stratified. The health care system was legally divided into six distinct subsystems—departmental, elite, capital city, industrial, provincial city and rural. Each subsystem served different population groups at differing levels of financing and standards of care.[1] Corruption and informal payments played a role, but had relatively less influence on access than the system's formal stratification (Davis 1988). The system was quite effective with broad public health measures such as vaccinating and screening, helping to bring adult life expectancy and infant mortality close to European norms in the 1970s, but this achievement proved temporary. By the 1980s the system had become outdated and increasingly ineffective, unable to modernize to provide the more sophisticated treatment required for complex and chronic conditions such as cancer and cardiovascular disease. The disparity between basic health indicators in Europe and Russia grew during the 1980s, then spiked in the 1990s (see Fig. 10.1). Evidence of popular dissatisfaction also grew. By the late Soviet period, the health care system was deficient in comparative international terms, characterized by chronic shortages of pharmaceuticals and advanced diagnostic equipment, utilizing low levels of medical technology in generally poor health facilities (Tragakes and Lessof 2003).

The Soviet health care system left three critical legacies that have continued to shape the present. First, the new Russian state inherited a large public health care bureaucracy and labour force, networks of administrative organizations and health care personnel who had vested interests in the

[1] In the 1980s less than one-half of 1 percent of the population had access to the elite system, while about half were served in the lowest-quality, rural district system (Davis 1988). Education and social status also played important roles in health care utilization (Rusinova and Brown 2003).

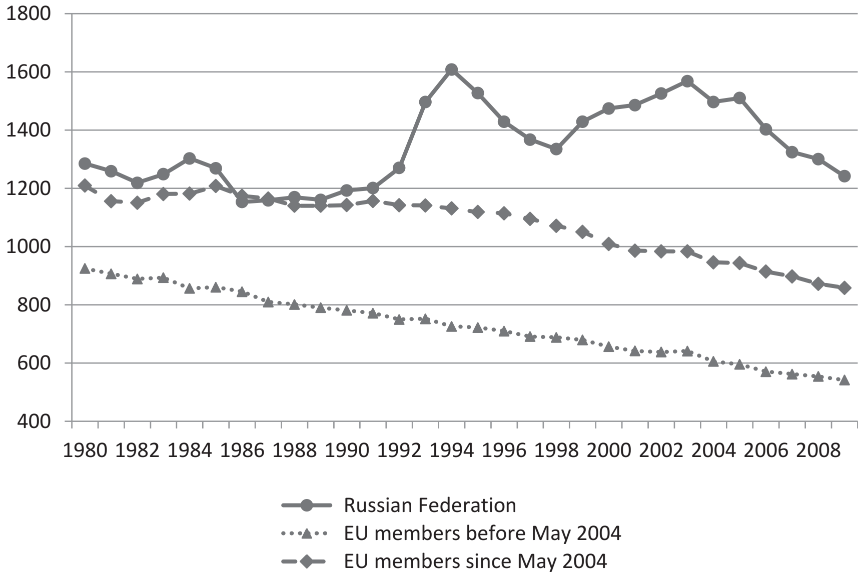

Fig. 10.1 Age-standardized death rate (SDR), all causes, all ages, per 100,000 in Russia compared to EU member countries (*Source*: Author based on data from WHO HFA Database (WHO "Europe Health For All (HFA) Database" 2006–2013. Accessed 15 November 2012. http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db))
Note: SDR is the age-standardized death rate calculated using the direct method, that is, it represents what the crude rate would have been if the population had the same age distribution as the standard European population

old system of state administration and input-based planning and financing. These interests would stand as an obstacle to marketizing and efficiency-oriented reforms of health care financing and practice, as would the absence of private providers or financing mechanisms. Second, the system had entrenched norms and practices of overstaffing and excessive reliance on specialization and hospitalization, and these would prove difficult to change. Third, the system left a mixed legacy of universalism and inequality.

Given the emphasis of this chapter—and of the broader United Nations Research Institute for Social Development project—on possibilities for universal health care, it is worth considering some of the problems and

limitations even when the Soviet system approached universal provision of basic health care, and lessons they might have for the present:

1. "Universal care" concentrated resources on diagnosis and treatment of disease, rather than on its prevention. It is widely recognized that high rates of cardiovascular and other chronic diseases in Russia's current population require both better health care and major preventive efforts.
2. "Universalism" in the Soviet context meant coverage of the population by facilities and providers more than quality and effectiveness of care. General consensus holds that reforms must focus on quality and effectiveness, and that simply spending more on the existing infrastructure of staffing and institutions is unlikely to help.
3. The Soviet system relied on broad screenings of the population at school and work to diagnose infectious diseases, and often on hospitalization to treat them. The main contemporary infectious diseases (TB, HIV/AIDS) tend to be concentrated among at-risk populations such as intravenous drug users and sex workers, who are often socially excluded and do not attend school or registered workplaces. Broad screenings are therefore ineffective in covering these populations, while the threat of mandatory hospitalization (still sometimes used for TB and routinely for drug addiction) may deter some from seeking care. Targeted forms of outreach and less coercive policies are therefore needed.
4. While basic health care was available to poorer and less-educated Soviet citizens, it was often low quality and ineffective. Ethnographic evidence shows that many people in these strata delayed seeking care and relied on self-treatment as long as possible, though this was obviously not an option for serious health problems (Rusinova and Brown 2003). The lesson here is that health services must be not only available but decent and dignified, or people may avoid seeking care until illnesses become serious and expensive, or impossible to treat. Experts argue that in order to fulfil its promise of universalism and effectiveness, Russia's health care system must mitigate the worst financial inequalities, focus on prevention, reach at-risk groups and improve overall quality.[2] The chapter's conclusion returns to these points.

[2] Potapchik et al. (2011), World Bank (2011a), UNDP (2010).

The Decline and Reform of Health Care in the 1990s

With the Soviet collapse in late 1991, Russia's political economy was thrown into a crisis that featured a decade-long economic decline, hyperinflation and rapid increases in poverty and inequality. Ramifications for the health care system were severe: overall levels of state financing fell by an estimated one-third, by mid-decade state salaries for the majority of health care workers had fallen below the subsistence level, key pharmaceuticals were in deficit supply and the large inherited stock of health care infrastructure was deteriorating (Goskomstat 2001, 2002). At the same time, the official poverty rate grew to 25 percent of the population (with some estimates higher), and inequality spiked (Cook 2007). The cumulative effects helped to drive Russia's health indicators to their lowest levels at the end of the 1990s (see Table 10.1). The main causes of adult mortality were cardiovascular disease, cancer and external causes, such as accidents and poisonings, often alcohol-related and concentrated among working-aged men, though infectious diseases also played a role. Incidence and deaths from TB more than doubled during the decade (UNDP 2010). Russia's population began a generation-long decline in numbers that was driven mainly by excess middle-aged male mortality, with low birth rates also contributing.

President Yeltsin and his domestic and international advisors sought to address the problems of Russia's health care system through a series of liberalizing and marketizing reforms that formed part of their broader policy of economic "shock therapy". During the first half of the 1990s the health care system was decentralized, partially privatized and moved to an insurance model that was supposed to introduce competition and provide choice for patients. New legislation legalized private outpatient practices, pharmaceutical and medical equipment production and distribution were privatized, and formal ("cash register") payments were introduced for some health services (Davis 2001). Most responsibility for financing and policy was devolved from the federal government to 89 regional health committees. The inherited system of single-payer public budget financing was replaced by a new system of mandatory health insurance (MHI). Health Insurance Organizations were created

to purchase medical care from providers according to a "competitive contracting" model. Together these reforms constituted an "overnight massive de-statization of medical care … extending shock therapy into the health care system" (Twigg 1998: 586). Within the space of a few years, a decentralized public–private mix, underfunded and poorly regulated, replaced centralized state control, planning and finance (TACIS 1999; OECD 2001). At the same time the Russian Government codified its commitment to free universal health care in the 1993 Constitution, Article 41, which remains in force today.

The 1990s reforms had significant and lasting effects on Russia's health care system. They shifted a substantial part of the burden for health expenditures to households and regions. Federal budget financing for health care fell from 100 percent to about 50 percent (see Table 10.2). The proportion of household payments for health services and pharmaceuticals increased substantially, to almost 30 percent of the total. The average share of medical expenditures in household income grew steadily from 1994 to 2004, though it has since declined.

Spontaneous Privatization and Shadow Commercialization

The economic decline and institutional chaos of the 1990s contributed to another set of effects on health care: practices of "spontaneous privatization" and "shadow commercialization" emerged on a large scale, in part as survival strategies for impoverished health care workers (Cook 2014a).

Table 10.2 Main sources of health care financing in the Russian Federation (percent of total)

Source of finance	1995	2000	2005	2009
Government revenues	48.4	35.7	36.0	39.4
MHI funds	25.5	24.2	26.0	25.0
Out-of-pocket payments	16.9	30.0	31.3	28.8
Private insurance	1.6	3.2	3.1	3.9
NGOs	2.8	1.7	1.8	1.4
Other private sources	4.8	5.2	1.8	1.5

Source: Based on data from Popovich et al. (2011: 73) and WHO (2006–2013)
Note: *MHI* mandatory health insurance, *NGO* non-governmental organization

Despite substantial defunding of the health sector, most health infrastructure remained in operation during the 1990s, the number of providers in some categories appears to have grown, and the state continued to mandate the free provision of most health services. As public expenditures became patently inadequate to support existing infrastructure, personnel and guaranteed services, health professionals turned to informal income-generating strategies that became known in the Russian medical sociological literature as "spontaneous privatization" and "shadow commercialization," a "tendency to spontaneous and unofficial replacement of free services with paid ones".[3] Increasingly health sector administrators, doctors, nurses and others used control over access to facilities and professional skills to impose informal or "shadow" payment requirements for treatment.

By the mid-1990s informal payments had come to play a significant role in access to medical services. People at all income levels were paying out-of-pocket, and while these payments included some legal "cash register" changes, many were informal. The proportion of the population paying for medical services increased steadily from 1994 until 2004, with the proportion paying for hospitalization increasing from 13 to 46 percent, and for diagnostic tests and procedures increasing from 9 to 23 percent (Popovich et al. 2011; Shishkin et al. 2008a). Charges varied according to medical specialties, hospital departments, localities, patients' social and income groups, inpatient and outpatient care, and arbitrarily. Survey evidence from the early 2000s indicates that surgeons may have supplemented their official incomes by between five and ten times, rank-and-file doctors by two or three times, and nurses and others by between one-fifth and two times (Shishkin et al. 2003). Many providers and some patients considered these payments as fair reimbursement in light of the extremely low official health sector salaries (Shishkin et al. 2003; Blam and Kovalev 2003). Large-scale corruption emerged, particularly in pharmaceuticals, the one part of the health sector that was largely privatized. Collusion between providers and pharmaceutical companies over drug pricing became common (Vacroux 2004, 2005).

[3] Feeley et al. (1999), Blam and Kovalev (2003, 2006), Cook (2014a).

The combination of growing poverty and inequality, the underfinancing of the health sector and informal payment requirements had, by the late 1990s, excluded some sectors of Russian society from access to guaranteed health care. While Russian citizens could visit their local polyclinic (publicly managed clinics that provide basic medical care), there was great differentiation in the scope and quality of services available for different regions, localities and income groups. Substantial numbers reported abstaining from medical treatment or being unable to complete treatment regimes, particularly to obtain prescribed pharmaceuticals, because of the cost. Higher-income groups could access high-quality private care in major cities, while poorer and rural strata spent higher proportions of their incomes for lower-quality services. An Organisation for Economic Co-operation and Development (OECD) report on the Russian health care system pointed to "a growing underclass without access to care" (OECD 2001) in Russia at the end of the 1990s.

2000–2010: Putin, Progress and Persistent Problems

By 2000, Russia's economy had entered a period of strong and steady growth that lasted until the 2008 recession. At the same time the rise to power of Vladimir Putin strengthened state administration, including the governance of the health sector. The drivers of Putin-era health policy and reforms, both fiscal and political, stand in sharp contrast to those of the Yeltsin era. While Yeltsin's government was driven to cut costs in a period of sharp economic decline, and moved towards market solutions under Western influence, Putin used a budgetary surplus to turn policy back in a statist direction (Cook 2010). In an economically resurgent Russia, the Putin administration focused on population decline and low birth rates, especially their negative implications for economic development and national security. Putin declared health and social policy as "priority tasks" in addressing the demographic crisis. His policies succeeded in greatly improving the performance of Russia's health sector, but also confronted obstacles and persistent problems.

After 2000, government expenditures in the health sector grew, salaries recovered, the Health Ministry reasserted control over the system and new regulations and price controls were imposed on pharmaceuticals. Mid-decade, the government launched a pro-natalist campaign that brought improvements in care for pregnant women and newborns, then added programmes directed at diseases that had been contributing to high mortality rates, such as TB and cancer. In 2008 officials made raising access and quality of health care for the whole population a major priority (Shishkin et al. 2008a, b). These efforts contributed to the improvements in health outcomes and indicators that are shown in Table 10.1. The government also launched a series of reforms that were designed to deal with problems inherited from the 1990s, including salary increases to reduce incentives for informal payments (Tompson 2007; Shishkin et al. 2008b). The health insurance reform was revived in the hope of introducing competition, cost controls and consumer choice into the system. Efforts were made to move away from input-based financing of the health sector, to introduce output-based and qualitative measures of effectiveness, and to differentiate medical professionals' salaries according to performance. Salary scales were adjusted to reward primary care practitioners and to discourage the system's entrenched over-specialization. The need to narrow the range of medical services included in the package of health care that was guaranteed to every citizen was recognized, and proposals to introduce means-tested medical assistance for the poor were discussed.

By the end of the decade, these reforms, in combination with rising incomes and declining poverty, had produced positive results. Key indicators of life expectancy, particularly child and maternal mortality had improved, and rates of major infectious diseases had stabilized. Health care became more accessible, and informal payments less pervasive, though health sector wages stayed near the bottom of the urban wage scale. (Potapchik et al. 2011). However, insurance reforms overall again largely failed (Popovich et al. 2011). Practices and structures inherited from the Soviet period, including input-based financing, overspecialization and overreliance on hospitalization, proved remarkably persistent. The "Guaranteed Package" continued to promise more health care than the government could or would fund. And while state funding for the health sector grew with the economy, "welfare effort"—the proportion

of GDP expended in the public health sector—remained nearly stable at a modest 4 percent of GDP, according to the authoritative European Health Observatory's 2011 assessment of Russia's health system:

> The scope and depth of health reform has varied widely across the Russian Federation depending on the commitment of regional and local authorities, but there is much evidence that it is possible to effectively restructure regional health systems…successful reforms require holistic and well-sequenced approaches. …Partial reforms produce imbalances. (Popovich et al. 2011: 146)

Russia's Contemporary Health Care System: Institutions, Actors and Processes

At present, health care for Russia's population is provided by three categories of institutions: public, private and non-governmental organizations (NGOs) or international non-governmental organizations (INGOs). The system remains overwhelmingly public, with polyclinics, hospitals and research centres falling variously under federal, regional or municipal control. The number of institutions in the public sector has decreased sharply since 2000, with 40 percent of inpatient and 28 percent of outpatient facilities closed, most of these being small rural hospitals (*uchastkovye*) and other facilities from the Soviet period that were considered obsolete and marginal (Popovich et al. 2011). Changes in the number of health personnel, by contrast, has varied across categories with the overall number per 10,000 population remaining near its 1990 level. While the oversupply of specialists has been somewhat mitigated by wage incentives for paediatric and family care practitioners, the provider–patient ratio in Russia remains high by international standards. In sum, post-Soviet governments have had limited success in reforming the massive health sector infrastructure and labour force they inherited.

Russia's formal private health sector remains small and is concentrated in urban areas and in certain specialties such as dental clinics. As of 2010, the whole of the Russian Federation had only 124 private hospitals, 120 of them in major cities (federation-wide there are more than 6500 hospi-

tals) (Popovich et al. 2011: 38). A small voluntary health insurance (VHI) system operates in large Russian cities, covering less than 5 percent of the population, purchased mainly by employers and providing access to privileged facilities (Potapchik et al. 2011). Some Russian citizens also access cross-border care, or engage in health tourism. Upper-income urbanites travel abroad, principally to Israel, Germany and Finland, but also to other destinations for various types of care at their own expense (Tikkanen 2005; Budiansky 2012). There also remains a "parallel" system of health care provision that is run and financed by some governmental ministries, providing privileged access to ministry personnel and their families and those in voluntary insurance schemes. Finally, there is a small NGO sector in health that plays some role in the direct provision of care and health policy advocacy, mainly in the area of infectious diseases, especially HIV/AIDS (Lussier and McCullaugh 2009; Pape 2014). A few NGOs/INGOs, including the WHO and the International Organization for Migration do outreach and advocacy for migrant workers' health care. These organizations play a constructive but limited role in the health sector.

Financing and Administration

As explained above, Russia's health care system is financed by a mix of general budget revenues (about 40 percent), health insurance funds (25 percent), out-of-pocket payments (almost 30 percent) and VHI. NGOs and other private payments make up the residual 1–2 percent. Per capita expenditures have increased substantially in real Rubles due to growth in GDP (see Fig. 10.2). However, as noted above, the level of "welfare effort" in health, a key measure of public commitment, has remained fairly stable at about 4 percent of GDP. This is a moderate level of effort given Russia's level of development, and well below OECD and European Union (EU) averages. Private health expenditure reportedly accounts for another 2–3 percent of GDP, bringing total health expenditure to above 6 percent. The proportion of private to public expenditure is high in comparative terms, an expenditure pattern that is associated with poorer public health outcomes (Starodubov et al. 2007; Popovich et al. 2011).

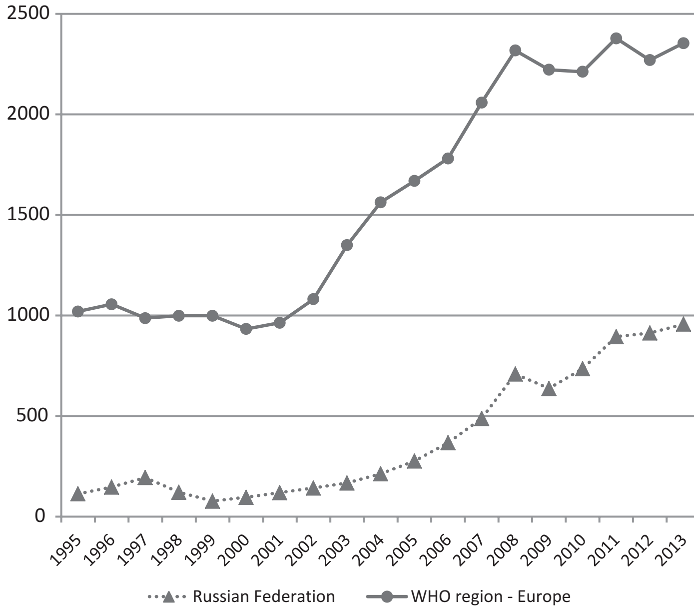

Fig. 10.2 Total per capita expenditure on health in Russian Federation and WHO European region, 1995–2013 (*Source*: Author based on data from WHO Global Health Observatory data repository. Accessed April 15, 2016. http://apps.who.int/gho/data/view.main.HEALTHEXPCAPEUR?lang=en)

Obstacles to Universal Access and Drivers of Fragmentation in Russia's Health Sector Inequality[4]

Three distinct dimensions of inequality affect access to health care in Russia: household level, regional level and rural–urban differences within regions. At the household level, Russia's economic recovery and growth from 2000 to 2008 brought rising incomes and declining poverty, but high levels of

[4] This section draws on the results of numerous national surveys, including the Russian Longitudinal Monitoring Survey, 1994–2000 (http://www.cpc.unc.edu/projects/rlms-hse, accessed 03 March 2016), the National Survey on Public Well-Being and Engagement with Social Programs (NOBUS) in 2003 (World Bank 2005) as well as regional surveys reported in Aarva et al. (2009) and Blam and Kovalev (2006).

inequality still persisted and even grew among particular demographics. According to Remington's authoritative study in the Russian Federation, "Inequality rose with poverty in the 1990s, and then rose still faster in the 2000s as poverty declined" (Remington 2011: 38–39). High levels of inequality helped to produce large disparities in the levels and types of health care accessed by patients. Evidence from the Russian Longitudinal Monitoring Survey shows that use of paid facilities has increased steadily among the top income quintile while disparities in the use of private services between the wealthiest quintile and all others have grown since 1998 (Popovich et al. 2011). Russians in the top income quintile seek medical help almost 40 percent more often than those in the bottom quintile, and spend twice as much in absolute terms, but ten times less as a share of their income than the bottom quintile (Blam and Kovalev 2003, 2006). The vast majority of patients and payments go to the public sector, including both "cash register" and out-of-pocket payments, and the overall burden of expenditure is income-regressive, that is, the proportion of expenditure on health care is much higher in poorer households.

There is also stark differentiation in fiscal capacity, per capita expenditure and health outcomes across Russia's regions (now consolidated from 89 to 83 regions). Russia's post-2000 economic growth led to sharp polarization between regions by level of economic development and per capita GDP. The cross-regional distribution of health financing became more unequal during economic recovery. In 2011 the reported difference in real per capita expenditures between the highest and lowest-spending regions had increased to ninefold to tenfold (Shishkin 2006; World Bank 2011a). The distribution of medical personnel and facilities is also very uneven across Russia (see Figs. 10.3 and 10.4). Residents of poorer, less-developed regions spend higher shares of their income on health care than those living in wealthier regions, often because no free specialists or diagnostic equipment are available in poorer regions, while residents of wealthier regions typically pay to get higher-quality care. Health outcomes differ starkly across regions. There is, for example, a threefold to fourfold difference across regions in the key indicator of infant mortality (Shishkin 2006; World Bank 2011a).

Within each region, urban–rural differences are also significant. Rural populations have less access to health services, and poorer overall health, than do urban populations. Federation-wide, the average number of

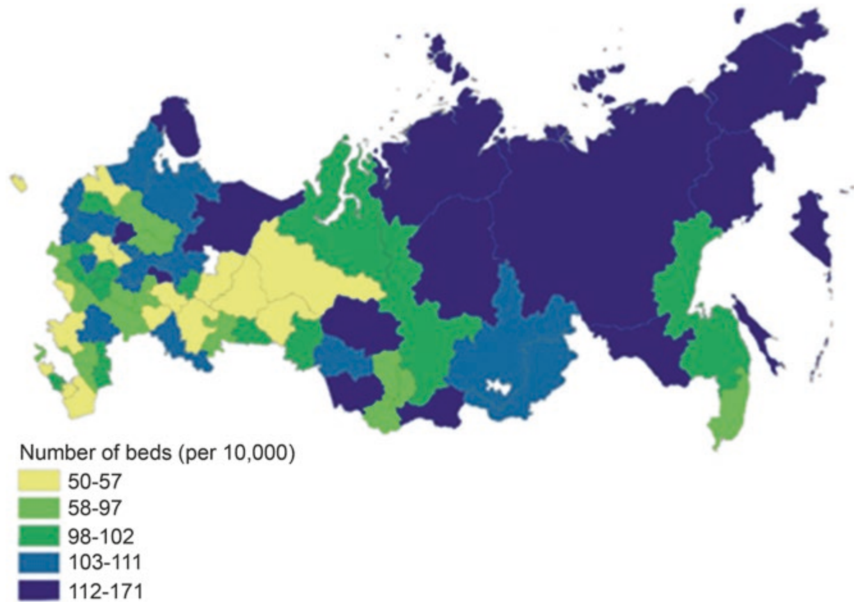

Fig. 10.3 Distribution of hospital beds by region in Russian Federation, 2009 (*Source*: Figure created by the author in ArcGIS using data from Rosstat (2009))

doctors is almost 50 per 10,000 population in urban areas, and a little over 12 per 10,000 in rural areas. As the European Health Observatory assessment summed up the situation, "the poorest segments of the population receive the least medical care" (Popovich et al. 2011: 167). In all contexts, men's health is worse than women's: there is a 12-year gender gap in life expectancy, while for the working-age population, male mortality is three times higher than female.

Informality and Out-of-Pocket Payments

The practice of informal payments persisted through the period of economic growth and increasing state expenditure on the health sector. According to the well-known health sector expert Shishkin, "Despite the growth of state financing of health care and of state-guaranteed free services, informal payments seem to have increased. Forty-five percent of

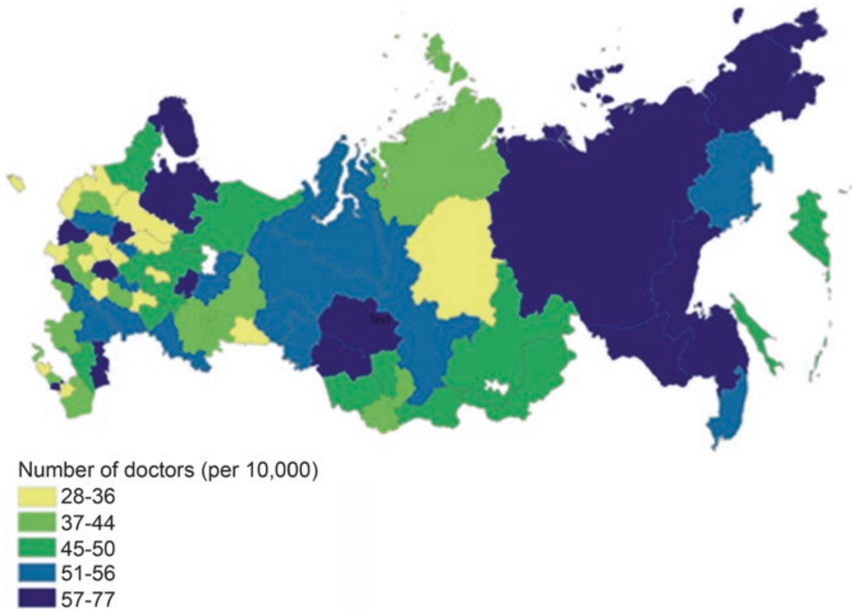

Fig. 10.4 Distribution of doctors by region in Russian Federation, 2009 (*Source*: Figure created by the author in ArcGIS using data from Rosstat (2009))

doctors surveyed said that 'envelope' payments had increased in the past five years, forty-two percent that such payments had remained stable" (Shishkin et al. 2008b: 231). While the proportional contribution of informal payments to doctors' incomes appears to have declined, there is evidence that the practice took on systematic, market-like features, responding to relative wages, the degree of expertise and the quality of equipment. Payments depend on both the type of institutions and the doctors' level of qualification; they are higher in regional and urban hospitals and lower in district (*raion*) hospitals and small cities. In a national survey on health care access, most respondents said that they received some free services, but the survey concluded that patients who do not pay when asked or who ignored hints risked not being admitted to a hospital or being admitted to a very crowded ward; not receiving current medications, but cheaper ones; having older technology used; having a

less-qualified surgeon; and not receiving adequate attention from doctors and nurses (Shishkin et al. 2008b: 242–243). The 2003 National Survey on Public Well-Being and Engagement with Social Programs found that between 10 and 20 percent of patients could not get access to care or complete treatment regimes because of cost, often the cost of pharmaceuticals (World Bank 2005; Manning and Tikhonova 2009).

One meaningful measure of the realities of health coverage limits is access to the government's "Guaranteed Package" of care, which is supposed to be covered by Mandatory Medical Insurance. The package specifies free-of-charge services to include consultation with a GP or specialist and two or three diagnostic procedures. In practice, access to this combination of services usually requires payment. Catastrophic medical expenditures—that is, spending of more than 30 percent of household income on medical care—affected more than 8 percent of households in the mid-2000s, including 5 percent of the top income quintile and 10 percent of the bottom quintile.

Research, however, shows recent improvements in indicators of health care inequality and exclusion. By 2009, national survey evidence found declines in the percentage of households whose members abstained from necessary medical help because of their inability to pay. Informal payments became somewhat less pervasive for outpatient (though not for inpatient) care, and less coercive (Potapchik et al. 2011). Interbudgetary transfers from the federal level to regions have somewhat diminished regional differences in per capita social expenditures (World Bank 2011a). Huge increases in expenditures for HIV/AIDS (see below) have made free antiretroviral (ARV) therapy available to many of those affected by the disease.

Social Exclusion: Unregistered Migrants

The discussion in this chapter so far applies to health care for Russian citizens, legal residents and those registered to work and who are covered by the MHI system. Two population groups are often subject to social exclusion. First is the large and shifting population of migrant workers. Russia now has the second-largest international labour migrant population in the world, after the United States (Buckley et al. 2008; Heleniak 2008).

Although pejorative stereotypes in Russian media and elsewhere often present migrants as health threats with high rates of infectious diseases, research finds that those arriving generally exhibit the "healthy migrant effect," a tendency for migrants to be healthier overall than the receiving society because of their youth, positive health selectivity and better health behaviours (in respect of drinking, smoking and diet) than the native Russian population (Buckley et al. 2011). A number of factors militate against migrants remaining healthy, including poor living and dangerous working conditions. As long as workers are informal, employers bear virtually no responsibility for their health and safety conditions. Several studies have shown that levels of information about transmission, prevention, diagnosis and treatment of common infectious illnesses (that is, TB and HIV/AIDS) among migrants are low (Weine et al. 2008; Gilpin et al. 2011). The Russian Federation is committed, under international agreements, to provide emergency medical care to all in its territory. Research in Moscow during spring 2012 confirmed that public facilities do provide emergency care to migrants who lack legal status, but little else (Cook 2014b). Migrants usually have to pay for all but emergency care, and even access to paid care (finding facilities that will accept them) can be difficult. Treatments are expensive relative to wages, leading many to wait out illnesses, self-treat or return home ill. Fear of being reported and deported or imprisoned also deters access.

Their unregistered status pushes some migrants into an informal economy where fake medical certificates and other documents may be purchased, and the potential here for undermining public health and monitoring measures is apparent, especially for infectious diseases such as TB. Excluding a large, vulnerable labour-active urban population from care, particularly for infectious diseases, acts against the success of public health goals and campaigns in Russian society.

Stigmatized Groups

Other stigmatized groups include sex workers, intravenous drug users (IDUs) and those living with HIV/AIDS: all populations that are vulnerable to multiple health problems. During the 1990s and early 2000s, the

numbers of people in these categories grew rapidly while they were largely excluded, or self-excluded, from public health services. The Russian medical communities' approach to IDUs, held over from the Soviet period, remains largely punitive. It requires official registration and sometimes involuntary detoxification, and generally rejects methadone therapy, rehabilitation and harm-reduction measures such as needle exchanges (Kramer 2011). IDUs became a significant source for the spread of HIV/AIDS in the mid-1990s, with Russia experiencing one of the highest rates of increase in the world by the early 2000s, though absolute numbers of cases remain moderate by international standards and regional incidence varies greatly.

Until 2005, the federal government paid little attention to HIV/AIDS, despite the urgings of international organizations to prioritize its treatment and prevention (Twigg 2007). That neglect has led to a disproportionate impact on young Russians: HIV/AIDS has a prevalence rate of over 1 percent among those aged 18–24 years (Twigg 2007). NGOs and regional governments did step in to provide ARV therapy, counselling and guidance to people living with HIV and AIDS; needle-exchange programmes for IDUs; condoms and counselling for sex workers; and broader education programmes directed to youth and the general population (Lussier and McCullaugh 2009; Pape 2014). Here civil society organizations helped to fill the gap left by the state's neglect. At the same time, these actors have limited capacity and reach; they cannot provide comprehensive or coordinated public health approaches and campaigns that would be adequate to deal effectively with such major public health problems federation-wide. From 2005, there was a dramatic shift in policy. The government has devoted much more policy attention and resources to HIV/AIDS, with massive increases in expenditure. It has mounted impressive efforts, establishing a network of regional AIDS centres that provide ARV therapy and other services. However, those groups most at risk—IDUs, sex workers, gay men—continue to be stigmatized. Efforts to humanize the treatment of IDUs have been resisted and reversed, and the overall conservative, patriarchal and explicitly anti-homosexual ideology of the Putin administration continues to reinforce exclusion.

Assessing Russia's Health System: Performance and Outcomes

After declining sharply during the 1990s, the health status of Russia's population has improved greatly since 2000. It is difficult, of course, to separate the impact of health policies and programmes from broader improvements in living conditions over the same period in accounting for health gains. However, indicators that are considered sensitive to health interventions, such as the levels of infant, under-five and maternal mortality, have seen the greatest improvements, and compare well relative to other states with similar levels of development and health expenditure (World Bank 2011a) (see Table 10.1). Increased financing and other modernizing measures have contributed to improvements across all regions. Standard vaccinations cover 97–98 percent of the population. There have been impressive gains in control of communicable diseases: 75 percent of those newly diagnosed with TB are now getting WHO-recommended treatment, up from 44 percent in 2004, while TB mortality has declined by 25 percent (Popovich et al. 2011; UNDP 2010). The effects on increased life expectancy are also shown in Table 10.1.

In recent years the Russian government has begun to address broader behavioural factors that affect the population's health, including smoking, alcohol consumption, diet and exercise. The National Health Concept sets out ambitious targets and concrete measures, including the promotion of "healthy lifestyles". In 2010 the government adopted a National Anti-Tobacco Policy Concept, based on ratification of the WHO 2008 Framework Convention on Tobacco Control. Recent policy initiatives stress the priority of preventive measures in public health protection. "healthy lifestyle" programmes are directed particularly to young people, and include at least some information about STDs and HIV/AIDS prevention (though most schools still do not provide instruction in these areas). The goals set by the National Health Concept—to increase the population to 145 million, life expectancy to 75 years and decrease mortality to 10 deaths per thousand—are overly ambitious, and the effectiveness of these programmes remains uncertain, but the prioritization of preventive measures over curative health care represents a promising initiative (Popovich et al. 2011). At the same time, in comparative

international terms, health outcomes are not as good as they should be given Russia's level of development and health expenditure. While overall expenditure on health care is relatively low for the European region, with which it is often compared, it is in the expected range for middle-income countries. However, physical inputs in Russia are high relative to human development outcomes (Popovich et al. 2011). Rates of infectious diseases have stabilized but remain comparatively high: in 2010 Russia was still among the 22 countries most affected by TB and among the 10 most affected by multi-drug-resistant TB (UNDP 2010). The health system remains relatively ineffective at treating non-communicable diseases. Middle-aged male mortality remains exceptionally high. Women live longer, but experience comparatively poor health in their senior years. Overall levels of adult morbidity and disability are comparatively high. Much of the population reports low satisfaction with their health care in surveys. How can the efficiency and effectiveness of the system be improved?

Policy Recommendations

Most recommendations for efficiency improvements in Russia's health care system focus on technical aspects of reform, proposing changes in organization, management and financing. These recommendations make sense, and experiments based on them in some Russian regions have produced positive results (World Bank 2011a). Such efforts should continue, but by themselves seem likely to produce limited results. Another major recommendation made by analysts is for the Russian Government to focus much more on preventive measures, including education, as well as tax increases and regulatory policies that limit access to tobacco and hard liquor. To date, there have been some initiatives towards education and stronger regulatory policies in these areas.

Inequalities in distribution and access to health services also contribute to the Russian system's poor performance and inefficiency. There is some evidence that equalizing trends in expenditure are effective in improving efficiency and performance. For example, regional gaps have narrowed significantly in indicators that have been the focus of federal financing

and policy—that is, maternal and infant care—indicating the effectiveness of equalizing expenditure (UNDP 2010). Other proposed equality-enhancing reforms would extend insurance coverage to outpatient prescription drugs and de-stigmatizing outreach and harm-reduction programmes for marginal groups, extending treatment for infectious diseases to migrants, and ultimately expanding the system of work permits so that all can register. These would limit exclusion and potentially improve the effectiveness of public health measures in Russian cities. Overall, public health expenditure is low relative to private expenditure, a pattern generally associated with poorer public health outcomes. While "throwing money at the problem" may not help, a structure of expenditure that is more public, less out-of-pocket and more equal seems likely to improve performance, efficiency and the overall health of the Russian population.

Conclusion

Russia's health care system has a number of strengths: it aspires to universalism, providing a constitutionally guaranteed right to health care for all its citizens. Public policy is designed to include all citizens in the MHI system. The government is seriously committed to the control of infectious diseases through public health measures, and has lowered rates substantially from the 1990s. Access to free emergency medical care appears to be universal. The system has prioritized the needs of newborns, mothers and young children. Since 2005, the government has directed much more funding and attention to HIV/AIDS, and has permitted regional and non-governmental actors to introduce harm-reduction and education efforts. The recent initiation of "healthy lifestyle" programmes represents a progressive move towards a preventive rather than a curative approach to health care. The very significant overall improvements in key health indicators since the 1990s, though partly a product of economic recovery and income growth, should be recognized and appreciated. It is striking that health care expenditures and performance have improved markedly, even as governance has moved in an increasingly authoritarian direction, providing an exception to much of the recent comparative literature that finds a correlation between democracy and health across many states.

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11

The Fragmented Social Protection System in India: Five Key Rights but Two Missing

Santosh Mehrotra, Neha Kumra and Ankita Gandhi

Introduction

India's economy has grown at an impressive rate in recent years, yet the incidence of income (or consumption) poverty remains large, with 269 million persons (or 22 percent of its population) living below the national poverty line.[1] Since 2004–2005, the absolute number of poor has been declining for the first time in India's history, but the proportion of the population that suffers from capability deprivation is still high. This is demonstrated by the fact that one-third of adults suffer from malnutrition, around 30 percent of children below five years of age were considered malnourished in 2013 (Ministry of Women and Child Development 2015), 310 million persons (or 26 percent of the population) were illiter-

[1] This poverty line is quite close to the international poverty line of USD 1.25 per person per day.

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ate and life expectancy at birth, although having risen, remained around 65 years in 2011 (IAMR 2011).

India remains an outlier among emerging market economies in terms of the share of workers in informal employment (93 percent) (Mehrotra et al. 2013). It is expected that social insurance will be available for the unorganized sector workers, in addition to universal coverage of preventive and even public health care. However, both a social insurance system and the public health system are limited in coverage and fragmented in character; lacunas which will be addressed in this chapter.

The progression of India's welfare system from treating citizens as mere beneficiaries of state-provided welfare to a rights-based approach is a relatively recent one. The implementation of the right to work (albeit in rural areas), the right to education and the right to food demonstrate major achievements towards an entitlements-based approach. However, in a country where a large proportion of the population lives below the poverty line and a huge proportion of the workforce is in informal employment, it is imperative that all persons have access to universal preventive and public health services. Furthermore, full coverage of social insurance (old age pension, death and disability insurance, maternity benefits) should be available at least to the poor among those who work in the informal sector. In the absence of publicly provided health care, such insurance might allow access to a preventive and basic curative care package.

In light of these goals, this chapter examines the strengths and weaknesses of India's health care system. It discusses the factors leading to the enactment of fundamental rights—to work, education and food—then presents health outcome indicators and an overview of India's health sector before making a case for universal health coverage.

Right to Employment, Right to Education and Right to Food

Human rights and human development are interrelated (Alston and Bhuta 2005). Moreover, rights or entitlements, by their very definition, impose claims on other people or institutions to help or collaborate in ensuring access to some freedom (UNDP 2000).

In India, Article 21 of the Constitution guarantees a fundamental right to life and personal liberty and Article 47 of the Constitution makes it one of the primary duties of the State to raise the standard of nutrition and the standard of living and to improve the public health of its people. In addition, the provision of social protection is enshrined in Articles 38 (securing a social order for the promotion of welfare of the people), 39 (certain principles of policy), 41 (right to work, education, and public assistance in certain cases), 42 (just and human conditions of work and maternity relief) and 43 (living wage, etc.) of the Constitution as part of the Directive Principles of State Policy. In this context, civil society mobilization and political support have resulted in a focus on universalization and entitlements in respect of education, employment and food.

In the legal context, an important development has been the decision of the highest appellate court—the Supreme Court of India in the early 1980s—to waive off traditional doctrines of standing and pleadings to permit concerned citizens, public interest advocates and non-governmental organizations to petition it on behalf of individuals or communities suffering violations of constitutionally protected rights (Alston and Bhuta 2005). By way of development of its Public Interest Litigation jurisdiction, the Supreme Court of India has come to act as a "combination of constitutional ombudsman and inquisitorial examining magistrate, vested with responsibility to do justice to the poor litigant before it by aggressively searching out the facts and the law, and by taking responsibility for fully implementing its decisions" (Neuborne 2003: 503).

Furthermore, the National Advisory Council (NAC), created in 2004, provided support to the idea that the state has a key role to play in the provision of minimum levels of employment, education and food as basic entitlements to every needy citizen in the country.

The NAC, along with the civil society movement, was instrumental in the enactment of the National Rural Employment Guarantee Act in 2005. The NAC also played a key role in providing impetus to the government's flagship programmes in rural health, nutrition, education, infrastructure and urban renewal. For the purpose of this chapter, it is important to note that the NAC was a creation of the central government, led by the Congress Party (2004–2014), and was disbanded by the new government (led by the Bhartiya Janata Party) in May 2014.

The new government announced in early 2015 a new National Policy Framework for Health.

Before turning to a further discussion of health, we present below some landmark legislation of recent times—the right to employment, right to education and right to food.

Right to Employment

In India, a major focus for rural development has been the productive absorption of the underemployed and surplus labour by the provision of direct supplementary wage employment to the rural poor through public works (Second Administrative Reforms Commission 2006). The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) of 2005 represented a paradigm shift towards fulfilling the long-standing demands of the Right to Food Campaign and the labour movement in India. The Act stipulated that any adult willing to undertake casual labour at the minimum wage is entitled to employment on local public works within 15 days, subject to a limit of 100 days per household per year (Gazette of India 2005).

Under the MGNREGA, an employment scheme was launched, implemented during the period 2006–09 to cover all the 600-odd rural districts in the country. The scheme sought to enhance the income of the poor by providing employment, and through the process of employment helped to create durable assets leading to much-needed productive infrastructure for sustainable poverty alleviation. Moreover, it has been suggested that the worker's organizations would lead to linking the employment guarantee with social security schemes, and the greater bargaining power would also help rural workers in the realization of other social and economic rights (Drèze and Khera 2009).

It is argued that the challenges for successful implementation of the MGNREGA stem from five factors: the focus on universalization and entitlements; the funding by the union government and execution by the state governments; the centrality of local governments; administrative and institutional arrangements; and the problems in less developed areas (Second Administrative Reforms Commission 2006). Furthermore, for the success of any entitlements-based programme, close attention should

be paid to the circumstances that shape people's perceptions of their rights as well as their ability to enforce them (Drèze 2004).

It is worth mentioning that as a result of the MGNREGA, rural open market wages have risen from Indian Rupee (INR) 65 in 2006–07 to INR 128 in 2012–13, partly because the wages provided under the programme were higher than the prevailing rural market wages (The Hindu 2014). The MGNREGA made work available locally, giving landless labourers an alternative to migrating to urban or other rural areas in search of work, or working on the landlord's farm (Mehrotra 2008). An impact evaluation of the MGNREGA using the capability approach finds a significant expansion in the capability set of the individuals interviewed (Dasgupta 2013).

Right to Education

The right to education was first recognized as a fundamental right by the Supreme Court of India in the judgement of *Mohini Jain* v. *Union of India* (1992) 3 SCC 666. A strong civil society demand for the right to education was responsible for its enactment. In December 2002, the Indian Parliament passed the 86th Amendment to the Indian Constitution, which mandated the provision of free and compulsory education. After a participatory process of inviting comments from members of the public, the Right of Children to Free and Compulsory Education Act or Right to Education (RTE) Act was passed by the Indian Parliament in August 2009 and came into force in April 2010.

The RTE Act guarantees free and compulsory education to all children aged 6–14 years, stipulates a pupil–teacher ratio of 30:1 at the primary level and 35:1 at the upper primary level, and has provisions for improvements in school infrastructure (IAMR 2011). Schooling is provided free-of-cost (including indirect costs such as uniforms, books and transportation) until a child's elementary education is completed.

The *Sarva Shiksha Abhiyan* (SSA), a programme working towards the universalization of elementary education which pre-dated the RTE Act, is now implemented in partnership with state governments to cover the entire country. SSA seeks to open new schools where facilities are lacking and to strengthen existing school infrastructures through the provision

of additional classrooms, toilets, drinking water, maintenance grants and school improvement grants.[2]

The impact of the RTE remains questionable, however. The Annual Status of Education Report (Pratham 2012) found that India is very close to achieving universal enrolment, with levels for children aged 6–14 years at 96 percent enrolment or more for the previous four years. However, though pupil–teacher ratios have shown improvement in rural areas, learning levels have dropped in many states since the RTE Act came into effect. This may be attributed to the absence of exams and assessments in the new regime, leading to the relaxation of teaching and productivity.

Right to Food

The Right to Food Campaign is an informal network of organizations and individuals campaigning for the realization of the right to food, through the state guarantee of entitlements relating to livelihood security, such as the right to work, land reform and social security. The campaign began with a writ petition submitted to the Supreme Court in April 2001 by the People's Union for Civil Liberties, Rajasthan. This was followed by a larger public campaign resulting in the Supreme Court of India appointing Commissioners on the right to food.

As a result of civil society mobilization and political support, the government approved the National Food Security Act (NFSA) in 2013. The entitlements under the NFSA include an assured quota of subsidized food grains (rice, wheat and millets) from the Public Distribution System (PDS), maternity benefits for all pregnant women and nutritious meals for children through local *Anganwadis* or primary schools. The NFSA aims to cover 75 percent of rural and 50 percent of urban populations (Department of Food and Public Distribution).[3]

It has been argued that for the NFSA to have an impact on hunger in India there needs to be improvement in the governance, productivity and accountability of the public sector. Major food-related programmes,

[2] See http://ssa.nic.in/ (accessed September 2015).

[3] Department of Food and Public Distribution website, accessed 13 March 2016. http://dfpd.nic.in/nfsa-act.htm.

such as the PDS of wheat and rice and Integrated Child Development Services, are plagued by corruption, leakages, errors in selection, procedural delays, poor allocations and little accountability. Moreover, they discriminate against and exclude those who need them the most (Saxena 2012; Mander 2012). It has also been argued that the magnitude of the subsidy under NFSA is huge and thus imprudent (Bhalla 2013). Unless the PDS is radically reformed, it has been suggested that a cash transfer equivalent to the value of the cereals entitlement would be more appropriate (at least in cities).

Despite a plethora of demands for a comprehensive "Food Entitlements Act" from the Right to Food Campaign, state governments have failed to reform PDS and the NFSA has been implemented in only 11 of India's 29 states.

The India Human Development Report (IAMR 2011) highlighted a conceptual framework regarding the feedback loops that run through human development inputs and outcomes. Thus, nutrition, education and income (employment) are all important inputs that feed into better health outcomes. The above narrative suggests that these entitlements-based public programmes can play a crucial role in improving overall human development outcomes, including indirectly health outcomes, provided they are timely and adequately monitored and evaluated.

The Two Missing Rights: Social Insurance and Health

While progress has been made towards the three fundamental rights in India—education, food and work—there are two that are completely absent: social insurance and health.

It is argued that social security consists of two categories of support to workers: first, social assistance and second, social insurance (Mehrotra 2015). Social assistance (assistance in kind or cash) is intended for those who are unable to work (for example, the old and indigent, disabled and poor widows) or those who are unable to earn enough from work to guarantee a basic income or consumption level. Social insurance is intended for those able to work but with limited access to a safety net that

is normally available in the organized sector as a form of health coverage (old age pension, maternity benefit and death or disability benefit). It is argued that the Indian state has so far failed to provide effective social insurance for its people (Mehrotra 2015).

Social security interventions remain fragmentary in India. Government-sponsored and -administered programmes dominate pension and health insurance provision in India. However, in distributional terms, social security coverage is concentrated in the upper part of the income distribution and fails to reach the vast majority of the population. One of the reasons for this low coverage of social security is the extent of the informal work sector (World Bank 2011b). While 93 percent of the Indian labour force is in informal employment, less than 1 percent of workers in the unorganized sector have any formal pension coverage through public schemes. The coverage through commercial schemes is only 1.2 percent for personal accident insurance, 0.5 percent for private health insurance and 23 percent for life insurance (O'Keefe 2005).

A social insurance programme, it is argued, should be comprised of three components—old age pension, death and disability benefit (or life insurance) and maternity benefit in line with the internationally recognized minimal requirements by the International Labour Organization's 2012 Social Protection Floors Recommendation (ILO 2012). These safety nets provide crucial support in times of health hazards which can potentially hurt poor families and push them further into the shackles of poverty. In line with the needs of the unorganized sector as highlighted in the NCEUS report (NCEUS 2008), we argue that social insurance should also include a national health insurance mechanism for those in the unorganized sector. Thus, providing for social insurance and universal preventive health care systems are important concerns to be addressed in developing country frameworks to improve the overall productivity and capabilities of their population.

Health Outcome Indicators

Health is an important facet of human development and well-being. Health inputs as well as health outcomes have important implications for nutritional and learning outcomes. Ensuring universal coverage of

health services is an important component in universalizing social protection. An assessment of health outcome, process and input indicators reveals that despite the National Rural Health Mission (NRHM),[4] progress in terms of these indicators has been slow to be able to achieve the Millennium Development Goals (MDGs) (IAMR 2011).

The development goal to eradicate extreme poverty and hunger required halving the proportion of those suffering from hunger between 1990 and 2015. The estimate of underweight children (an indicator of food insecurity) has shown some improvement in the past decades. While the proportion of underweight children aged 0–3 years was 53.5 percent in 1990, it was estimated to be 47 percent in 1998–99 according to the second National Family Health Survey (NFHS), and 46 percent in 2005–06 as per the third NFHS. A 2013 survey by the central government (supported by UNICEF) provided the latest available estimates and found that the level of malnutrition had fallen to around 30 percent (Ministry of Women and Child Development 2015). The MDGs, however, required this proportion to be reduced to 27 percent by 2015—a goal which was ultimately not met.

The development goal to reduce child mortality required reducing the under-five mortality rate (UFMR) by two-thirds between 1990 and 2015, as well as reducing the infant mortality rate (IMR) to 26.7 per 1000 live births by 2015. There has indeed been progress in reducing child mortality rates in the last two decades, although much remains to be achieved (see Fig. 11.1). While IMR declined from 80 per 1000 live births in 1990 to 68 in 2000, the pace of decline slowed during the next decade, when IMR fell by only 24 points to reach 40 per 1000 live births in 2013 (Registrar General 2014). In order to achieve the MDG target, IMR would have needed to decline by another 13 points in the remaining two years.

The inter-state differences in IMR are more worrisome (see Fig. 11.2). While the national average in 2013 was 40 per 1000 live births, and the lowest was in Kerala (12), the relatively poorer states recorded an IMR much higher than the national average—Assam (54), Madhya Pradesh (54), Odisha (51) and Uttar Pradesh (50) (Registrar General 2014).

[4] The NRHM was launched in April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups.

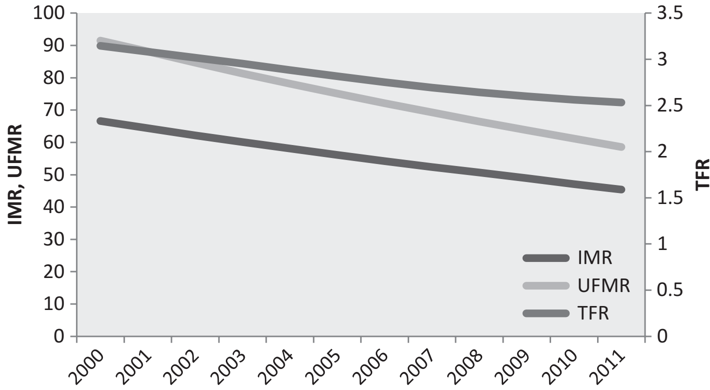

Fig. 11.1 Infant mortality rate (IMR), under-five mortality rate (UFMR) and total fertility rate (TFR) in India (*Source*: Author based on data from World Development Indicators)

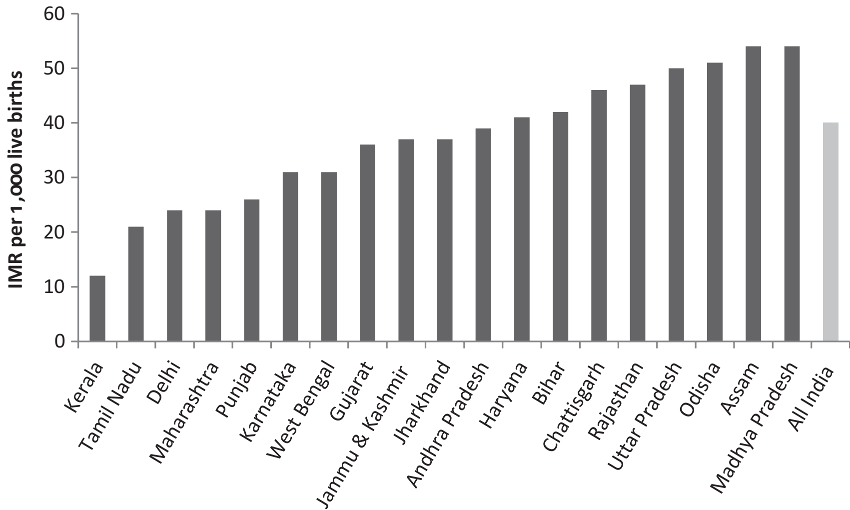

Fig. 11.2 Infant mortality rate in selected Indian states, 2013 (*Source*: Author based on data from Registrar General, Government of India (various years))

The UFMR, or the probability of a child not surviving to his/her fifth birthday, stood at 125 per 1000 live births in India in 1990. The MDG target was to reduce UFMR to 42 per 1000 live births by 2015. It declined to 85 per 1000 live births in 2000, to 55 in 2011, to 52 in 2012, and further to 49 in 2013 (Registrar General various years). However, for the poorer states of Assam (73), Madhya Pradesh (69), Odisha (66) and Uttar Pradesh (64), high levels of child mortality rates reflect the inefficiency of the public health institutions as well as a lack of entitlements for healthy living. These also implicate gaps in child immunization practices.

According to the third NFHS, 44 percent of children received all vaccinations[5] in 2005–06. This proportion was lower in rural areas where it was 39 percent, and even lower for rural areas of Assam and Madhya Pradesh (32 percent), Bihar (31 percent), Jharkhand (30 percent), Rajasthan (22 percent) and Uttar Pradesh (21 percent). In 2007–08, as per the District Level Household and Facility Survey estimates, 54 percent of all children received all vaccinations. However, in Madhya Pradesh, only about one-third of children received all vaccinations, a number that was even lower in Uttar Pradesh (IAMR 2011).

The health and nutritional status of the child is critically dependent on the mother's health and care taken during pregnancy and delivery. The maternal mortality ratio (MMR) measures the number of women of reproductive age dying per 100,000 live births due to maternal causes. MMR was as high as 560 in India in 1990–91 and the MDG target was set at 140 by 2015. MMR declined dramatically to 301 per 100,000 live births in 2001–03 and declined by 89 points to reach 212 per 100,000 in 2007–09. The MMR stood at 178 in 2010–12, falling to 167 in 2011–13 (Registrar General various years), but still far from the MDG target of 140.

At the state level, it is seen that Kerala (66), Tamil Nadu (90), Maharashtra (87) and Andhra Pradesh (110) have realized the MDG target of 140 per 100,000 live births. The most significant decline in average MMR, from 308 to 257, was seen in those states participating in the Empowered Action Group[6] and in Assam. However, Assam remained

[5] One BCG injection to protect against tuberculosis, three doses each of DPT (diphtheria, pertussis, tetanus) and polio vaccines, and one measles vaccine.

[6] The Empowered Action Group was set up to facilitate preparation of area-specific programmes in eight states, namely Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar

a major drag on the MMR with 328 deaths per 100,000 live births, along with Odisha (235), Rajasthan (255) and Uttar Pradesh/Uttarakhand (292). The suboptimal performance in terms of these indicators (child mortality and MMR) reflect the gaps in antenatal care, skilled birth attendance and emergency obstetrical care in these relatively poorer states (Planning Commission 2013).

High MMRs can be attributed to the high incidence of non-institutional deliveries. Continued high rates of child and maternal mortality suggest that the public health system has been ineffective in promoting reproductive and child health programmes and healthy practices such as breast-feeding, the use of oral rehydration salts, and preventive and care-seeking behaviours (Planning Commission 2013). Indian women suffer, in particular, due to their limited access to health care services during pregnancy. According to the third NFHS estimates for 2005–06, only 52 percent women had three or more antenatal care check-ups.

On average, only 39 percent of deliveries took place in an institution in India, according to NFHS data for 2005–06. In rural areas, the figure was even lower at 29 percent. According to the District Level Health Survey data, 47 percent of women aged 15–49 years had an institutional delivery in 2007–08. The Sample Registration System (SRS) of the Registrar General of India estimates of 2011, however, show that there has been a sharp rise in institutional deliveries, which can be attributed to the success of NRHM and the *Janani Suraksha Yojana*.[7] The percentage distribution of births by type of medical attention at delivery shows that about 13 percent of live births occurred in the presence of untrained functionaries or others. Government and private hospitals respectively accounted for 50 percent and 24.4 percent of deliveries, the remainder being accounted for by other qualified professionals (like female health workers or auxiliary nurse midwives) (Registrar General SRS Statistical Report 2013).

Pradesh and Uttaranchal, which have lagged behind in containing population growth to manageable levels.

[7] Janani Suraksha Yojana is a safe motherhood intervention under the NRHM. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme is under implementation in all states and union territories, with a special focus on “low performing states”.

Health Sector Overview

The performance illustrated by the health outcome indicators indicates gaps in the health system of the country. Improving the health conditions of the population requires investment in health infrastructure and human resources (IAMR 2011). The expenditure (public and private) on health has been abysmally low in India, hovering at around 4 percent of gross domestic product (GDP) in 2010 with the share of public expenditure in total health expenditure at 28 percent. The higher proportion of private expenditure on health results from the high out-of-pocket costs incurred by private households (86 percent of total private expenditure) (DGHS 2013). High out-of-pocket expenditure on health, especially by those belonging to the poorer sections of the society, often pushes them below the poverty line, particularly in the case of certain unforeseen circumstances.

In 2011–12, the combined public expenditure on health reached 1.04 percent of GDP. With additional spending on drinking water and sanitation, as well as the Integrated Child Development Scheme and Mid Day Meal Scheme, public expenditure on health rose to 1.97 percent of GDP in the period 2007–12. From 2012 to 2017, it is expected to rise to 2.5 percent of GDP (Planning Commission 2013; IAMR 2011).

Low public expenditure on health also reflects gaps in health infrastructure for both physical as well as human resources. Health infrastructure indicates the quality of health care delivery and, in turn, affects health outcomes. Despite the NRHM and increases in public expenditure in health, National Health Profiles for 2005 and 2013 (DGHS 2005, 2013) present an insubstantial increase in the number of subcentres (142,655 in 2004 to 151,684 in 2013), primary health centres (23,109 in 2004 to 24,448 in 2013) and community health centres (3222 in 2004 to 5187 in 2013). According to the World Development Indicators of the World Bank, compared to the figure of 36 hospital beds per 10,000 people in China, India has just nine hospital beds per 10,000. The severe shortage of public health infrastructure can be illustrated by the fact that the average population served per government hospital is 98,970. The situation is much more severe in certain other states, however: it is as high as 451,325 in the

case of Bihar, 229,118 in Uttar Pradesh, 194,863 in Assam, 178,243 in Andhra Pradesh, 159,721 in Haryana, 155,470 in Madhya Pradesh and 139,676 in West Bengal. The average population served per government hospital bed is 1,512, but is more than 5,000 in the cases of Bihar and Jharkhand and over 3,500 in Uttar Pradesh and Assam (DGHS 2011).

The availability of skilled human resources is an important prerequisite for effective health service delivery. The number of allopathic doctors possessing recognized medical qualifications (under the Medical Council of India Act) and registered with state medical councils increased from 656,111 in 2005 to 921,877 in 2011 (an increase of around 40 percent). There has also been an improvement in the average population served per government allopathic doctor from 15,980 in 2005 to 12,005 in 2011. However, the increase in doctors in primary health centres in rural areas was only 20 percent over this period. It is noteworthy, however, that there was an almost 50 percent increase in female health workers or auxiliary nurse midwives between 2005 and 2011 (see Table 11.1).

In 2008, the government launched its flagship health insurance scheme for the poor: the *Rashtriya Swasthya Bima Yojana* (RSBY).[8] This combines technology with incentives to provide inpatient insurance coverage up to an annual sum of INR 30,000 for eligible enrolled households. The RSBY is implemented through insurance companies with premiums subsidized by union and state governments to the extent of 75 percent and 25 percent respectively.

The population coverage under various publicly financed health insurance schemes increased from almost 55 million people in 2003–04 to about 370 million in 2014 (or almost one-quarter of the population) (Ministry of Health and Family Welfare 2014). However, this coverage is low given

[8] A well-designed and implemented health insurance may both increase access to health care and may even improve its quality over time. The RSBY provides the participating below-poverty line household with freedom of choice between public and private hospitals and makes them a potential client worth attracting on account of the significant revenues that hospitals stand to earn through the scheme. The coverage extends to five members of the family, which includes the head of the household, a spouse and up to three dependents. Beneficiaries need to pay only INR 30 or lower as a registration fee while central and state government pays the premium to the insurer selected on the basis of a competitive bidding. The budgetary allocation for RSBY was INR 264.51 crore in 2009–10, INR 445.89 crore in 2010–11, and INR 279.94 crore in 2011–12 (*Source*: http://www.rsby.gov.in/, accessed 13 March 2016).

Table 11.1 Government health human resources in rural areas in India, 2005 and 2011

Year	Doctors at primary health centres	Specialists at community health centres	Health assistants		Health workers	
			Male	Female	Male	Female/ANM
2005	21,974	3953	20,086	19,773	60,756	138,906
2011	26,329	6935	15,622	15,908	52,215	207,868

Source: National Health Profiles 2005 and 2011 (DGHS 2005, 2011)
Note: *ANM* auxiliary nurse midwife

that 50–60 percent of the country's population is vulnerable to poverty. It is argued that insurance schemes that cover only hospital expenses, such as those being rolled out nationally in India, will fail to adequately protect the poor against impoverishment due to the extent of many other health care costs beyond hospitalization (Shahrawat and Rao 2012).

Another study finds that the impact of RSBY on financial risk protection in India's health care is questionable (Selvaraj and Karan 2012). An examination of the poorer households in intervention districts of the RSBY, Rajiv Aarogyasri of Andhra Pradesh and Tamil Nadu Health Insurance schemes finds a rise in real per capita health care expenditure, particularly with regard to hospitalization, and an increase in catastrophic headcount, defined as the "number of households making out-of-pocket payment expenditure greater than 10 percent of their total household expenditure" (Selvaraj and Karan 2012: 62). This is "a conclusive proof that RSBY and other state government-based interventions failed to provide financial risk protection" (Selvaraj and Karan 2012: 60).

Towards Universal Health Coverage

In India, inequalities in health care by socioeconomic status, geography and gender persist, and three-quarters of health spending is private. Moreover, health expenditures are responsible for pushing around 39 million Indians into poverty each year. Consequently, India's health care system is posed with the challenge of responding to the needs of the most disadvantaged members of the Indian society (Balarajan et al. 2011).

While the civil society movements for the rights to education and work are long-standing and were largely responsible for the enactment of those rights, the historical civil society momentum for the right to health is missing. Health, both as the state subject and later as the concurrent subject, continued to be neglected until the 1990s. Economic reforms to dismantle the 'licence-quota raj' in the economy were characterized by liberalization and deregulation since 1991. For the health sector, this reform period was characterized by a mindset that favoured the introduction of user charges in public hospitals, private sector development and the growth of private health care. Also, public health issues as safe sanitation were recognized as important only in the last decade—according to the Census of India 2011 estimates, 69 percent of all households in rural India did not have a toilet—though the mindset started to change after the economic growth picked up in 2003–04. These developments have set the stage for a demand for universal health care in India.

More recently, the draft National Health Policy (Ministry of Health and Family Welfare 2014) proposes to make the right to health justiciable:

> The Center shall enact, after due discussion and on the request of three or more States (using the same legal clause as used for the Clinical Establishments Bill), a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable. States would voluntarily opt to adopt this by a resolution of their Legislative Assembly. States which have achieved a per capita public health expenditure rate of over INR 3800 per capita (at current prices) should be in a position to deliver on this—and though many States are some distance away—there are states which are approaching or have even reached this target. (Ministry of Health and Family Welfare 2014: 56)

It is argued that such a policy formulation/resolution would be the right signal to give a push for increased public health expenditure, as well as for the recognition of health as a basic human right and its realization as a goal that the nation must set for itself. The draft policy aims at increasing the government expenditure on health to 2.5 percent of GDP from the currently abysmal rate of 1 percent, ensuring universal access to free drugs and diagnostics at government hospitals. The proposal for a National Health Rights Act, along similar lines to those covered in the

Act, is indeed a very welcome step in ensuring an individual's fundamental right to universal access to affordable health care services. However, the existing apparatus poses dire challenges in achieving a public health care system that enacts health as a fundamental right, whose denial can be "justiciable".

A high-level expert group (HLEG) on universal health coverage (UHC) was earlier constituted in 2010 by the Planning Commission of India. It was entrusted with the mandate of developing a framework for providing easily accessible and affordable health care to all. In its report the HLEG recognized that it is possible for India, even with the financial resources available to it, to devise an effective architecture for health financing and financial protection that can offer UHC to every citizen. The HLEG made recommendations regarding a number of different areas: health financing and financial protection; access to medicines; vaccines and technology; human resources for health; health service norms; management and institutional reforms; community participation and citizen engagement; and gender and health (Planning Commission 2011).

The recommendations of the HLEG are wide-ranging and lack prioritization. We argue that India needs to focus on five key areas given the scarcity of resources and especially human resources for health.

First, all doctors should be required to serve in rural areas regardless of the requirement for a postgraduate seat (Rao et al. 2012).[9] Several states in India—Assam, Arunachal Pradesh, Chhattisgarh, Gujarat, Kerala, Manipur, Meghalaya, Nagaland, Orissa, Tamil Nadu and West Bengal—have made it compulsory for all the medical graduates to serve in rural areas (Gupta et al. 2010).We argue that this policy should be extended to all states on account of the huge public subsidy on doctors' education, and cite the experience of Sri Lanka, where the compulsory rural posting of doctors in the 1950s enabled substantial reduction in mortality in all

[9] From the experience of two Indian states, Uttarakhand and Andhra Pradesh, it is argued that linking postgraduate programmes to rural service appears to be an influential incentive for attracting doctors to rural posts. There is a strong desire for specialization among doctors after medical qualification (MBBS), which, coupled with few available postgraduate seats compared to the number of medical graduates, makes for intense competition in obtaining admission to postgraduate programmes (Rao et al. 2012).

areas and in every population group (Rannan-Eliya and Sikurajapathy 2008; Alailama and Sanderatne 1997).

Second, there is a strong case for the introduction of a three-year course for rural practice in all states in line with the experience of rural medical assistants in the state of Chhattisgarh (Rao et al. 2010). In many states of India, AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) physicians are posted at primary health centres in an attempt to mainstream the Indian systems of medicine. Often they are the sole clinician present and practice both allopathic and their own system of medicine (Rao and Ramani 2013). Clinicians with three years' training in allopathic medicine operate in two states. In the state of Chhattisgarh, rural medical assistants are posted at primary health centres, and in the state of Assam, rural health practitioners are posted at subcentres. In a recent initiative, the Central Health Ministry proposed the introduction of a national three-year clinician course, the Bachelor's degree in Rural Health Care, with the intention of stationing these graduates at rural subcentres (Rao and Ramani 2013). A study on non-physician clinicians in the state of Chhattisgarh found that physicians and clinicians with shorter duration clinical training (that is, rural medical assistants) were equally competent in managing conditions commonly seen in primary care settings (Rao et al. 2010).

Third, more regular staff or paramedics are needed to manage services and as frontline providers of services. The nurse to doctor ratio in India (1.5:1 instead of the desirable 3:1) is poor in comparison with other countries (Reddy 2012). This is because nursing training institutions have been left to wither, despite a great need for nursing skills.

The availability of competent and committed health workers requires that attention be paid to both the numbers and the quality of these workers. There is a huge need to establish new medical and nursing colleges. In addition, priority should be given to locating these new colleges in states which have very few training facilities, and they should preferably have linkages with the district hospitals. The training of health professionals has to emphasize health system connectivity, problem-solving skills, team functioning and partnership with the community (Reddy 2012).

Fourth, the essential drug procurement system needs to be revamped. Essential drugs should be available at affordable prices in the public health system. To strengthen the logistics and management system of health care, Tamil Nadu Medical Services Corporation was established in January 1995, which is the apex body for purchase and distribution of generic essential drugs for government medical centres in the state.

Fifth, sanitation is important in terms of both nutrition and securing improvements in health status. For example, India accounts for nearly 60 percent of the 626 million people in the world who defecate in the open (and also 90 percent of the total in South Asia). This number is more than double that of the next 18 countries combined where open defecation is prevalent (UNICEF and WHO 2012). As per National Statistical Survey Organization data, the percentage of the population who have no access of any type of toilet facility was approximately 60 percent in 2002 and had improved only very little, to 49 percent, by 2009 (IAMR 2011). The approximate economic loss due to lack of adequate sanitation could be as huge as INR 2.4 trillion in a year, constituting approximately 6.4 percent of India's GDP in 2006 (Water and Sanitation Program 2011). These costs are associated with death, disease, accessing and treating water, as well as losses in education, productivity, time and tourism.

Improved sanitation has a direct impact on health, leading to other positive externalities. First, improved sanitation impacts directly on nutrition by reducing the probability of water-borne diseases resulting in conditions such as diarrhoea, which significantly affects the nutrient-absorbing capacity in individuals. Constant exposure to such diseases results in lower nutritional status and poor health outcomes. Since malnutrition accounts for half of all child deaths, sanitation also impacts health and nutrition outcomes such as mortality rates, height for age, etc. Second, improved sanitation in schools improves the enrolment rates of girls. Moreover, the effects of improved sanitation in schools go well beyond enrolment, and extend to actual learning and better cognitive skills (Mehrotra and Ghosh 2013).

Concluding Remarks

In this chapter, we have discussed the key role of civil society mobilization and political support through the NAC in India, resulting in a focus on universalization and entitlements with regards to work (albeit in rural areas), education and food. However, two rights are only available to a very limited share of the population: social insurance and health. The health system in India remains weak due to limited coverage and low public expenditure on health, leaving the poorest people vulnerable to poverty. Furthermore, this chapter finds that the government's flagship health insurance scheme for the poor, the RSBY, remains ineffective in terms of providing financial risk protection for India's health care, with inadequate coverage which does not include consultations outside of hospitalization. Last but not least, it argues for universal health coverage in India and suggests areas for immediate policy intervention in the health sector.

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The Drivers of Universal Health Care in South Africa: The Role of Ideas, Actors and Institutions

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Introduction

Access to health care for all in South Africa (SA) remains a key challenge for the country's policy makers. Debates concerning the optimal reform path have increased in urgency in recent years and led to the proposed introduction of a far-reaching and ambitious reform strategy—a system of National Health Insurance (NHI) (RSA DoH 2011). Despite the term "insurance", the reforms aim to achieve a universal tax-funded system: comprehensive, integrated and available to all South Africans irrespective of income tax or insurance contributions. The proposal seeks to make health care a social right of citizenship rather than a market product and is in keeping with the current international drive for universal health care in developing countries.[1] While there is consensus that universal health care is effective in improving coverage and health outcomes and

[1] UN (2012), WHO (2005), UNRISD (2010).

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in reducing the prevalence of catastrophic and impoverishing health expenditure for the poor (Lagomarsino et al. 2012; Moreno-Serra and Smith 2012), debate continues about the best mix of financing and service delivery mechanisms. Debates, however, do not concern only technical issues but reflect conflicts of interest between different stakeholders and are underpinned by ideological and normative disagreements about the appropriate goals of reform.

This chapter outlines the opportunities and challenges posed by the proposed NHI reforms in SA. It begins by outlining the country's current two-tiered health system and its limitations. The chapter then discusses what NHI is trying to achieve within this context and how it hopes to address existing problems, before finally examining the political, institutional and implementation challenges the reforms will face. While most attention has been thus far devoted to the structural requirements and fiscal affordability of universal coverage, less attention has been paid to wider challenges—in particular the important role played by key stakeholders tasked with implementing the reforms.

The South African Health System: Past and Present

South Africa is a middle-income country with a gross domestic product (GDP) of USD 420 billion (2010 estimate) and a population of 52.98 million people (Stats SA 2013). Its current health system is two-tiered in terms of financial and organizational structure, and is highly inequitable in terms of access and quality. In order to understand the challenges facing the present system it is necessary to place it in the context of the country's colonial and apartheid history.

During the apartheid era (1948–1994), SA was subdivided into a "mainland" comprising four provinces, and ten so-called Bantustans ("self-governing" territories), to which the majority of black South Africans were relegated. Separate health departments were established in each of the Bantustans and an inequitable, racially fragmented system of health care delivery became entrenched. Per capita health expenditure across the nation differed by threefold to fourfold between whites and

blacks and vast inequities existed in health status and access to facilities between race groups, rural and urban dwellers, and rich and poor. Large hospitals absorbed most of the public health sector budget, despite the majority of health needs requiring primary level and community based care. A lucrative and poorly regulated private health sector covering less than 15 percent of the population (mainly whites) accounted for 60 percent of total health care expenditure. A high prevalence of serious preventable health conditions directly linked to poverty, such as tuberculosis and malnutrition, afflicted the majority black population. The consequences became evident in the racially differentiated health status of the population once democratic rule was introduced in 1994, with black African, coloured and Indian health outcomes significantly worse than those of whites (May 1998).

Health Care Delivery and Outcomes in the Democratic Era

On coming to power in 1994, the health policy priority for the new democratic government was to build a national health system, to reduce inequities and to increase the availability, affordability and quality of care across the country. Part of the health system transformation involved the redistribution of resources from tertiary- to primary-level care, as well as between provinces. It was an unprecedented period of major policy, legislative, structural and budgetary change. Public sector primary care services became free and charges in public hospitals means-tested.

Structurally, the country was reunified and subdivided into nine provinces. The new SA consequently had a single national Department of Health (DoH), with nine provincial DoHs under its jurisdiction. The national DoH became responsible for determining policy norms and standards, ensuring a functional national health service at all levels of government and providing services which cannot be provided cost-effectively at lower levels (such as laboratory and diagnostic services and public health services for major epidemics and health campaigns). Provincial health departments became responsible for service delivery within national policy, norms and guidelines.

However, the reforms did not overcome the historical wide disparities of provision across the country or improve population health outcomes and there continues to be large variation in health outcomes across provinces. Average life expectancy for men between 2001 and 2006 ranged from a low of 44.8 in the Free State to 56.2 in the Western Cape (Stats SA 2013). In terms of service provision, the distribution of different kinds of public hospitals varies considerably across the nine provinces, with a concentration of District Hospitals (generally providing only primary care from public GPs and family physicians) in poorer provinces (Eastern Cape and KwaZulu-Natal) and a concentration of larger specialist regional and private hospitals in the richest provinces (Western Cape and Gauteng). Similarly, the greatest number of health professionals are either in the richest provinces, Gauteng (22 percent) and Western Cape (12 percent) or in the case of KwaZulu-Natal (30 percent), those which have large metropolitan centres (Stats SA 2013).

Currently, approximately 16 percent of the population utilize private health care, known as medical schemes. Unsurprisingly, since membership is predicated on employment status and/or wealth, membership is concentrated among wealthier households in wealthier provinces. While the poorest quintile of households account for approximately 1 percent of medical scheme beneficiaries, the richest quintile comprise 51 percent of all medical aid members. Access to medical schemes is still also racially differentiated. While almost 70 percent of white South Africans belonged to a medical scheme in 2011, this compared to 41 percent of the Indian population, 20 percent of the coloured and just 9 percent of the black African population. Finally, the provinces with the most resources also contain the highest numbers of medical aid members with both the Western Cape and Gauteng having about 25 percent coverage. In contrast, the poorer provinces register much lower membership, as evidenced in Limpopo (7 percent) and the Eastern Cape (11 percent) (McIntyre and Ataguba 2012).

Problems of the Current Two-Tiered System

The need to pursue universal health care in SA must also be understood then within the context of the failing and worsening state of the existing health system. The system confronts a significant quadruple "burden of

disease" of poverty (peri-natal and maternal diseases), non-communicable diseases, HIV/AIDS, and violence and injury (Coovadia et al. 2009) and on key morbidity and mortality indicators its performance is poor for a middle-income economy. SA has 0.7 percent of world population, but 18 percent of global HIV infections (20 percent among the 15–49 age group) and TB infection rates are also among the highest in the world. In terms of several targets of the Millennium Development Goals (MDGs), such as prevalence of underweight children under five years or child, infant and neonatal mortality rates, progress has actually been reversed. Infant mortality rates currently stand at 48 per 1000—much higher than the case in comparable economies. SA is one of only 12 countries globally where maternal mortality rates are deteriorating; presently, 625 per 100,000 live births compared to the MDGs target of 38 per 100,000. Overall life expectancy has actually reduced since 1994 and stood at 50 years for men and 54 years for women in 2008 (Stats SA 2008, 2013).

There are many factors that contribute to the absolute and relative poor health status of South Africans and as is now widely acknowledged, social determinants (particularly poverty, income inequality, high unemployment and poor living conditions) are an important part of the explanation (Harrison 2010; Health Systems Trust 2011). However, SA's failing health system is also an important explanatory variable—in particular, that the system remains highly inequitable (National Planning Commission 2011). Though SA exceeds the World Health Organization (WHO) recommendation that middle-income countries devote at least 5 percent of GDP to health (current health expenditure is 8.5 percent of GDP), the expenditure is inequitably distributed. Only 16 percent of the population belong to private insurance (medical) schemes, yet they consume over 50 percent of total health care expenditure; the remaining 84 percent relying on the underresourced public sector. In other words, approximately ZAR 11,150 (USD 1,207) per capita was spent on private patients in 2013 compared with just ZAR 2,776 (USD 300) per capita spent on public patients. In terms of the distribution of human resources, the structure is dominated by private practitioners: 59 percent of doctors, 93 percent of dentists and 89 percent of pharmacists are in private practice (McIntyre 2010; Ruiters and Van Niekerk 2012), resulting in a ratio of one GP for every 540 patients in the private sector, but 1:4000 in the public system.

Overburdened Public Health Sector

The quality of care received by the majority of the population dependent on the public sector is indisputably vastly inferior to the levels of care in the private sector and the levels of care necessary to achieve good health outcomes overall. Although, theoretically, primary health care services in the public sector are free and charges in public hospitals are means-tested, many barriers to access exist, including: the availability of facilities (especially in rural areas); the distance to facilities and the cost of public and emergency transport (RSA DoH 2012); and exemption policies being unevenly implemented throughout the country (National Planning Commission 2011). Most importantly, the lack of risk pooling, income cross-subsidization and government subsidies to medical scheme members deprives the public sector of the necessary public funds. Many communities in rural areas still cannot easily obtain care and many in urban areas rely on overcrowded public facilities with too few health professionals and poor equipment. There are also conspicuous differences in the quality of service provision in each sector regarding medicines, equipment, waiting times, cleanliness and infection control, and numbers and attitudes of health personnel (Mkokeli 2012; Kahn 2013a).

Private Sector Health Funding Crisis

However, it is not only the predicament of the public sector that is problematic. The private sector also faces a looming crisis of affordability and sustainability (Dambisya and Mokgoatsane 2012; Doherty and McIntyre 2013). Possibly the greatest challenge facing the private health sector is the rapid rise in expenditure, particularly by medical schemes. Though the membership of medical schemes is heavily concentrated among wealthier households, these households are nevertheless facing escalating and debilitating costs. Since the beginning of the 1980s, medical scheme contributions have grown far more rapidly than inflation, and since the early 1990s they have doubled in real terms. Average contributions increased from less than ZAR 4,500 per person in 1992 to over ZAR 9,600 per person in 2008 (in 2008 ZAR terms) and was approxi-

mately ZAR 12,000 (USD 1,299) in 2013. According to Statistics South Africa (2008) in 2006, contributions by members of medical schemes averaged 9 percent of total household income, but this average masked variations between 6 percent in respect of high-income members and 14 percent for lower-income members (McIntyre and Ataguba 2012). Moreover, although medical schemes cover most of the costs of health care, members are still required to make substantial out-of-pocket payments. In 2007, out-of-pocket amounted to more than ZAR 20 billion (Ataguba and McIntyre 2009) with more than 60 percent of these payments made by medical scheme members as co-payments in cases where either all family dependents or the full cost of a service is not covered, or where the scheme benefits have been exhausted.

The reasons for the increased costs reveal, to a large extent, the inherent inefficiencies of all private health care systems. We know from public and health economics that there exist intrinsic inflationary pressures within all market-based health systems, including the perverse incentives created by the "third party payer problem" and fee-for-service as well as high transaction costs.[2] However, these issues are particularly exacerbated in the South African case, where private sector ownership is highly concentrated and largely dominated by three large hospital groups and a few pharmaceutical manufacturers. While there are over 100 medical schemes, 12 of the largest control the market and one single company owns several medical scheme administrators. The industry has proved to be a powerful lobbying force that has consistently resisted government regulation of prices and working practices. Some have accused these groups of not engaging in price competition but acting instead in an oligopolistic fashion and using their market power to charge excessively high prices (Blaauw and Penn-Kekana 2010). Administration costs have also increased rapidly in real terms at rates far exceeding inflation (McIntyre and Ataguba 2012) and are presently 10 percent, excluding the further 9 percent attributed to managed care activities and broker fees (CMS 2008).

[2] Barr (2004), Donaldson et al. (2004), OECD (2003).

Problems of Weak Institutional, Governance and Fiscal Controls on Provincial Health Care Expenditure

The problem of inequalities between private and public health care provision is accentuated by the governance arrangements for the delivery of health care. The period following 1994 established new governance and fiscal institutions, which inadvertently impacted negatively on health policy and has arguably contributed to the failure of the current health system. The 1996 Constitution provided that health, social security and welfare were designated as Schedule Four Functions, which meant they were to be the concurrent responsibilities of the national and nine new provincial governments. As outlined earlier, the spheres of responsibility were divided between national policy formulation and provincial and local responsibility for delivery of health programmes.

This separation of policy determination (at national level) with policy implementation (provincial level) failed, however, to consider the extent to which poorer provinces with Bantustan legacies of weak bureaucratic and fiscal capabilities (such as the provinces of the Eastern Cape and Northern Cape), would be institutionally disadvantaged in their ability to implement the new health policies. The new provinces that inherited the former Bantustans recorded the highest levels of poverty and inequality in the country and, unsurprisingly, experienced the most severe problems in the post-apartheid era in delivering health services.

This problem was compounded by the introduction of the Intergovernmental Fiscal Relations Act of 1998, which introduced fiscal federalist funding arrangements. The objective of the act was to establish mechanisms for making provinces more accountable for their expenditure by providing them with greater autonomy over the prioritization and allocation of health and welfare functions at a provincial level. However, one major weakness in the restructuring of these new fiscal arrangements was that they did not ring-fence health funds. Instead, provinces were allocated a cumulative block grant for health, education and welfare services and they were then entitled to allocate the grant according to their own provincially determined priorities. This made funds for health spending vulnerable to redirection to other spending based on the political priorities of provincial politicians and it is undoubtedly the case that

fiscal federalism contributed to a health service delivery crisis in weaker provinces.

The National Health Insurance Proposal

It is these combined problems of inadequate public health services, the inefficient and escalating costs of private care and extreme and widening health inequalities that the current NHI proposals seek to address. Initially announced as a key priority by the African National Congress (ANC) in its 2009 Election Manifesto, the NHI proposals were eventually released in the form of a Green Paper for Public Consultation in August 2011 (RSA DoH 2011). The launch of the final White Paper, initially scheduled for late 2012, has been delayed and is, at the time of writing, still outstanding.[3]

The stated objective of the NHI is to put into place the necessary funding and service delivery mechanisms to enable the creation of an efficient, equitable and sustainable health care system in SA. In order to address the imbalances in access, utilization of services and health care outcomes among the different socioeconomic groups, the NHI proposals intend a fundamental transformation of the system. The new system will be underpinned by an NHI Fund which will provide financing for health care and will enter into contracts with public and private hospital specialists and GP practices to deliver services free of charge to every SA citizen and legal resident.

The NHI is based on a number of underlying principles and objectives, including universality, social solidarity, equity, efficiency, quality and effectiveness. Of these, universality and social solidarity are possibly the most pivotal since they assert that all citizens, regardless of their socioeconomic (or any other) status, will be able to access the same essential health care services on the basis of need regardless of their financial means. It redefines health care as a public good rather than a market commodity and entitlement as a social right. SA would thus join the majority of Organisation for Economic Cooperation and Development

[3] Between the time of writing and the publication of this volume, the White Paper was published in December 2015.

(OECD) National Health Service and Social Insurance health systems which encompass five key income cross-subsidies between population groups: from rich to poor, healthy to sick, young to old, individuals to families, and men to women.

Access and Quality

The primary objective of the NHI relates to expanding access to quality services for all South Africans and in the pilot stage of rolling out the NHI, considerable attention is being paid to the well-documented challenges of inadequate human resources, infrastructure, stewardship and management. Current government efforts include strengthening the system of primary and community health care with specialist teams to support maternal and child health services, formalizing networks of community health workers and boosting management capacity through a recently established academy to provide leadership and management training and courses for hospital chief executives and their managers. An Office for Health Standards Compliance has been established to inspect and accredit facilities and services and provide an independent ombudsman service. Greater uses of information and data and more focus on "strategic purchasing" to drive improvements in quality and coverage of services are also being prioritized.

While it is too early to evaluate the impact of these reforms, there is some evidence that access to primary care services has been expanded for a previously underserved segment of the population and that outreach programmes, health education and preventive health measures, such as the community and school health teams, are reportedly functioning well in some districts (Cullinan 2015).

Funding the NHI

The new system will be funded through general tax sources, a new mandatory employment insurance contribution for higher earners, additional windfall taxes and the removal of tax subsidies for private insurance. Both

employers and employees will contribute to the new NHI Fund. The proposed funding structure is highly progressive, especially given the context that approximately only 5.2 million South Africans are employed in the formal sector and currently pay income tax (that is, 19.14 percent of the working population) and estimated unemployment rates are between 25 percent and 40 percent (Kahn 2013b).

According to the 2011 Green Paper, it is anticipated that the NHI will require ZAR 145 billion additional funding over the next 14 years (USD 21 billion at 2011 rates). According to a KPMG report (2012), the NHI financing model predicts that fiscal resource requirements will increase from ZAR 125 billion in 2012 to ZAR 214 billion in 2020 and ZAR 255 billion in 2025 over a 14-year period (in real value terms as estimated in 2010). These figures must be compared to current spending on health (2010/11 figures), which was ZAR 101 billion, increasing to ZAR 110 billion in 2012/13 (2010 prices). Spending in the private sector through medical scheme contributions totaled ZAR 90 billion in 2009 (2010 prices). A total of over ZAR 227 billion was thus spent on health services in SA in 2010, equivalent to approximately 8.5 percent of GDP (RSA DoH 2011). It is predicted that per capita expenditure on health care will increase by 14 percent in real terms under the NHI arrangements (KPMG 2012).

It is anticipated that the reformed system will benefit from several efficiency savings, including lower overall administration costs, a greater emphasis on less costly preventive and primary care services and the benefits of the state's new monopsony powers. As a single payer and purchaser of services, the government will be able to take advantage of economies of scale and a new bargaining position vis-à-vis clinical providers. It is envisaged that rates of remuneration to both public and private clinicians will be the same for both groups and are thus predicted to be lower than those paid by medical schemes tariffs to private sector providers.

Organizational Structures

A complete reconfiguration of the institutions and organizations involved in the funding, pooling, purchasing and provision of health care

is planned. Key features involve the creation of an NHI Fund to collect, pool and distribute funds, a purchaser–provider split and devolved funding and management to district authorities as the new purchasers. In place of "historic budgets" (where public sector health institutions are allocated fixed budgets based primarily on past expenditure patterns), a process of "active purchasing" is anticipated where new district purchasing authorities assess population need and construct agreements and contracts with providers in a manner that links payment to performance and ensures appropriate, efficient and quality care for its local population. The NHI Fund will only provide finance to health facilities and providers that meet required quality standards set by the new Office for Health Standards Compliance, which reports directly to the Minister of Health.

The gatekeeping role of primary care clinicians and the referral system will be reinforced with strict referral protocols. In addition to the strengthening of the gatekeeping role of GPs, there will be a focus on primary health care (PHC) re-engineering more broadly. In order to address the poor health outcomes and high maternal and neonatal death rates outlined above, clinical specialist support teams will be deployed to work at district level and will include obstetricians, gynecologists, midwives, paediatricians, paediatric nurses, anaesthetists, as well as family physicians and PHC nurses. To improve equity in access, teams will be initially targeted in the most underserved areas. School-based services are a further component of the reorganized system and, in addition to general preventive services and curative referrals, will focus on child immunization, child sex and substance abuse, nutritional services, family planning services and HIV/AIDs related programmes.

The plan to introduce the NHI proposes detailed mechanisms for improving the efficiency of the tertiary sector by increasing the managerial autonomy of hospitals. This will entail providing hospital managers with more decision-making powers in budgeting and resource allocation, revenue generation and retention, human resources management, procurement of goods and services and estate management. It will be achieved through a gradual process of enhancing management training and competencies, establishing better remuneration and career paths, and strengthening the role of Hospital Boards.

Management at the District Level

The management of PHC provision (including GPs, pharmacists, dentists, optometrists, physiotherapists and psychologists) will be undertaken at the district level in order to avoid the NHI Fund having to purchase individual elements of PHC services from thousands of different providers. District Health Management teams will establish the necessary institutional structures that will have independent management authority to purchase and manage PHC services. They will contract with public and private providers within their district in order to ensure a full range of services are available to residents. It is planned that the capacity of District Health Councils throughout the country will be strengthened by improving political governance, oversight and accountability structures as well as managerial capacity.

The concept of District Health Systems was first developed as part of the 1997 White Paper reforms and well established by the time the NHI Green Paper was launched. The principles underpinning the model of District Health Systems include access to services, local accountability, community participation and decentralization. The model is very much aligned with other international best practices and WHO recommendations that a "District Health System is the best vehicle for implementation of PHC … and is the building block of a national health system" (WHO 2005).

Role of the Private Sector

Private health insurance will be allowed to continue, though tax subsidies for premiums will be removed and it is envisaged that insurance will eventually play only a complementary role. The goal is that ultimately the majority of the population, including the middle classes, will come to actively choose to use the new improved tax funded public system without additional complementary private insurance.

Though details about the role of private providers within the new NHI structure are still lacking, the current reality of significant staff shortages and capacity means that there will be a need to include pri-

vate GPs in the reformed system. Following initial public acrimonious debates between the government and private sector providers (Mail and Guardian 2011), the government subsequently softened its statements and acknowledged that private sector doctors (initially at least) are an essential factor in implementing a successful NHI. The exact organizational and provider payment arrangements are still being determined but range from the "contracting in" of private GPs through sessional periods in public facilities, to the "contracting out" to private health professionals to deliver services in their own facilities. It has also not yet been decided whether reimbursement will be based on fee-for-service, or capitation. Early research, however, suggests that private GPs have strong views on the reimbursement proposals and concerns that the likely tariffs and prices will not reflect "true" costs and compensate fully for medical training, overheads, transport and insurance (Surender et al. 2014).

Pilots

The NHI will be implemented over a 14-year period, starting with pilots in 11 selected districts from April 2012. They will test interventions that are necessary for implementing the NHI while also strengthening the functioning of the District Health System in order to facilitate a smooth national rollout ultimately (RSA DoH 2011). The pilots will assess the feasibility, acceptability, affordability and effectiveness of the proposals, including ways of engaging private sector resources for public purposes, and will assess the costs of introducing the new system and the implications of scaling up the innovation on a national level. They will also monitor and examine utilization patterns, population health outcomes and the extent to which communities are protected from financial risks. Criteria for the selection of the pilots in the most disadvantaged districts involved a combination of factors such as demographics, socioeconomic variables and health delivery performance (RSA DoH 2012).

Challenges to Achieving the NHI Plan

Despite the government's public determination to enact the NHI proposals, it is as yet unknown whether the arrangements will be implemented as envisaged. The proposals represent a radical and fundamental overhaul of the current system and, as such, face many obstacles and critics—the delayed publication of the White Paper, one conspicuous illustration of the ongoing tensions and uncertainties. While most attention has been devoted to the fiscal requirements and affordability of universal coverage, less attention has been paid to wider aspects: ideological and normative disagreements about the goals and nature of the NHI, the significant institutional challenges, and the role played by key actors and stakeholders tasked with implementing the reforms.

Competing Interest Groups and the Battle of Ideas

Although receiving strong support from organizations such as the WHO, the idea of a publicly funded and delivered universal health care system is still a contentious one in SA—provoking resistance and opposition across political, academic and private sector groups. At the heart of the debate is the question of whether health care is a "public good" rather than a market one and the connected issue of the extent to which the state should assume responsibility for its provision. Related to this are political economy debates about the relative merits of public versus private mechanisms for meeting health and other welfare needs.[4]

Though trade unions such as COSATU and civil society organizations such as the Treatment Action Campaign and the People's Health Movement have given strong support for the NHI, endorsing both its goals and design, opposition to the reforms from political parties, academic and other analysts as well as the private sector health businesses that arguably have the most to lose, has been intense. Given that the NHI reforms are quite different to past incremental reorganizations and will have far-reaching implications for the private health sector, it is unsurpris-

[4] Marmor and Wendt (2011), OXFAM (2009), Watson and Ovseiko (2005).

ing that many SA private health agencies—including hospitals, insurance companies and clinicians—are opposed to the measures, which many view as a threat to their commercial and professional interests (Blaauw and Penn-Kekana 2010). Historically, this sector has been a powerful stakeholder in shaping health care policy and is likely to be a strong lobbying force in terms of shaping the outcome of the NHI proposals.

Arguments range from traditional public sector critiques (the state will always be less efficient, innovative and consumer-oriented than the market) to attacks on the specific mismanagement and capacity of the SA system. Opponents, including the professions' major medical associations, have been successful in galvanizing media sources and the national debate and have raised concerns, especially among middle-class taxpayers and medical scheme members, about the future viability and sustainability of the health care system.[5] In 2013, SAMA, which represents the largest proportion of the medical workforce, argued that the proposed NHI would be "economic suicide" for doctors unless they were paid much higher rates than the public sector rates proposed (Loggerenberg 2013). In 2014, the South African Private Practitioners Forum publicly attacked the NHI, arguing that it was not affordable in the SA context, and pleading for Health Minister Aaron Motsoaledi to "enter into dialogue" with them (Archer 2014a, b) echoing a general discontent of the private sector who feel that they have not been sufficiently included in the consultation process. A public acrimonious dispute has resulted with polarization and mistrust on both sides.

While there has been no formal research to date into the views of patients and/or citizens about the proposals, media sources tend to emphasize widespread concern rather than support for the proposals—revealing anxiety about the quality of services, access to technology and drugs, lack of choice, unaffordability of the NHI and that the funding will excessively burden taxpayers.[6] Employer groups such as Business Unity SA have also indicated criticism and opposition to the proposals.

Of the main opposition political parties, the Democratic Alliance (DA) has articulated outright opposition to the proposals, arguing that

[5] Archer (2014a, b), Kahn (2014), Malan (2014).

[6] City Press (2012), Kahn (2013b), Cullinan (2012).

they lack credibility and are driven by ideology and party politics. The Independent Democrats (before they were absorbed into the DA in 2010) voiced similar concerns, stating that government must avoid sacrificing attention to detail in its rush to overhaul health care. Both parties warned that the middle classes would be the losers of the reforms.

More subtle tensions, however, also exist within the government itself regarding the design and nature of the proposed NHI. In particular, the Treasury has a cautious view of the fiscal implications of the NHI and is concerned not to alienate private sector health care providers. It has voiced public criticism of the Green Paper's lack of detailed strategy for reforming public health services and argued that more attention needs to be directed towards drawing in private providers to district-level health service provision. These disagreements about the extent to which the NHI should utilize private providers in delivering a public service are normative as much as technical in nature. Ongoing discussions between the Treasury and the DoH about the potential for the NHI model to include an element of "performance-related pay" both at the PHC and hospital level, and some element of "co-payments" (in order to incentivize "consumers" to reduce unnecessary demand) reflect the ideological debates that are occurring within government on the NHI.

Institutional Challenges: Human Resources, Management and Organizational Fragmentation

The challenge of producing sufficient health professionals for the NHI is a major one. Kahn (2013a) found that the nurse-to-population ratio decreased from 149 public sector professional nurses per 100,000 population in 1998 to 110 per 100,000 in 2007. Doctors working in the private sector increased from 40 percent of total doctors in the 1980s to 79 percent in 2007, while the vacancy rate for unfilled health posts in the public sector stood at 42.5 percent in 2012. Despite the aim of the government's Human Resource Strategy (RSA DoH 2012) to produce 2,353 medical doctors by 2025, the current capacity of the education system to produce new medical doctors is limited. Currently, medical schools produce 1,300 medical doctors every year. Producing an additional 1053

extra clinical graduates annually will require a near-doubling of the enrolment of medical students from 8,589 to 15,549.

Management capacity has also been identified as a major challenge. Failures in management include repeated reports of the catastrophic management of hospitals, overspending at all institutional levels, understaffing, a lack of implementation of the planned restructured PHC model, demotivated professionals and support workers and lack of retention of staff and an inability to fill vacant posts (RSA DoH 2012).

The key institutional challenge, however, given the inequalities between provinces, is the creation of a nationally uniform high-quality service irrespective of geographical location, since many provinces do not possess the capability to spend even their current health budgets, a prerequisite for the implementation of a universal system of provision. Thus in 2012, the Eastern Cape underspent on its public health budget by 52 percent (ZAR 191 million), the Free State by 35 percent (ZAR 134 million), Limpopo by 27 percent (ZAR 89 million) and the Northern Cape by 37 percent (ZAR 158 million) (Kahn 2013a). Moreover, the formal separation of national and provincial levels of governance, accompanied by federalist budgeting arrangements means that the central government has little leverage to ensure national policy priorities are uniformly implemented at provincial level.

Finally, though the government has been strategic in investing in key pilot districts to develop human resource and infrastructural capacity, the record of implementation of the pilots has not been promising, with a third of the pilot sites failing to spend their allocated grants by July 2013, a year after they were awarded. Only 2 percent of health facilities in the Eastern Cape pilot had the necessary equipment, medicines and space to allow private GPs to work in them (Kahn 2013b). Most tellingly, nationally, only 96 private sector doctors signed contracts to work in NHI pilot clinics between March 2013 and March 2014, well short of the target of 600 set for the year (Kahn 2014). Moreover, the majority of those participating were in Gauteng province (one of the richest and best capacitated provinces) with the lowest participation rate in the Eastern Cape site (Cook 2013). On this record, the NHI will take a much longer period to establish in many areas than the time line envisaged by government.

The Role of Frontline Actors in Policy Implementation

Historical and comparative analysis reveals that whenever health systems undergo radical reform, the role of providers, especially the medical profession, is, without exception, crucial in determining its eventual success and character.[7] Findings from early research (Surender et al. 2014) suggest that the SA government will face significant challenges in garnering the support of private GPs (who form the largest clinical constituency within private sector primary care) and it is unclear whether they will comply with the proposals. Main concerns revolve around remuneration, resistance to local state control, increased workload, clinical autonomy and concern about "blame" for the diminished quality of care. However, despite strong concerns from the majority of private practitioners, the study highlighted that opinions were not unanimous and there were differences in emphasis. Most public sector GPs, particularly those working in hospital settings were largely welcoming of the reforms, believing they would lessen their workload by increasing capacity in the private sector. Additionally, some private practitioners, particularly in smaller practices in less affluent areas, also welcomed the potential increased work prospects and better security of remuneration that the new arrangements afforded. It was apparent that not all practitioners faced the same sets of conditions and, consequently, there was variation of opinion and experiences among them.

Nevertheless, most media coverage suggests that the main response from the private sector is one of scepticism, opposition and anticipation that NHI will entail less remuneration but an increased workload for private GPs (Loggerenberg 2013; Fokazi 2013). Despite public statements about strengthening primary care services and the referral system, most of those surveyed believe it will lead to less empowerment for primary care providers, and morale is reportedly low. The most fervent response concerns resistance to local state control and there appears to be little confidence in its ability to implement or manage the new system (Kahn 2013a, c).

[7] Rodwin (2011), Le Grand (2003), Light (2000).

Summary and Conclusion: The Challenges and Possibilities of Universalizing South African Health Care

The NHI proposals set out a far-reaching path of reform for South African health care based on principles of social solidarity and universality. It is a hugely ambitious project which seeks to address the inadequacies and inequities of the country's historic and present health care system and improve its quality. However, in the years since the initial launch of the Green Paper in 2011, there has been relatively slow progress towards the realization of the goals and a conspicuous delay in the launch of the White Paper.

As illustrated in this chapter, there has been significant contestation about the planned reforms between the DoH and the private health care sector and between different sections of government. While it is too early to predict success or failure of the plan, there are indications that the government will face considerable challenges to its proposed reform path. This chapter has sought to highlight some of these challenges, in particular the role of ideological and normative conflicts surrounding the goals of the reforms; the institutional context, and the role of actors tasked with delivering the new system.

Firstly, since there is little consensus among key stakeholders about the nature or definition of the problem, it is unsurprising that there is lack of agreement about the appropriate goals or mechanisms for reforming the system. While the government has pointed to the commercialism and disproportionate power of the private sector as a major contributor to the current system's problems, others point to government failure (corruption, bloated bureaucracies and lack of managerial and technical capacity) as the fundamental problem. For these critics, rather than "build a new system on poor foundations" (Amado et al. 2012: 4), what is needed is for the existing public system to be overhauled and better administered. Equally, while the architects of the proposals have emphasized a discourse of social rights and distributive justice and sought to justify NHI in terms of ethical considerations, other sectors of government, in particular the Treasury, have taken a more "instrumental" approach, emphasiz-

ing the efficiency and developmental benefits of a healthier workforce. This divergence in problem definition and aspiration has to some extent become translated into disagreements in the strategies and mechanisms that should be used—in particular the extent the private sector should be both accommodated and relied upon in the new NHI system. The South African case demonstrates that achieving consensus with key stakeholders and, crucially, the support of the wider central government are crucial if the momentum for far reaching health reforms is to be maintained.

Secondly, the political and institutional challenges for reforming the South African health care system are formidable and the existing evidence suggests that the country has limited capacity to establish a genuinely comprehensive universal system of health care. In particular, provinces with ex-Bantustan legacies will require a massive investment of infrastructural resources to upgrade and expand health facilities and information and communication technology systems. Perhaps more challengingly, they will need to undertake a systematic overhaul of their health management systems and recruitment of additional health personnel. However, it is equally true that the problems outlined are not unique to ex-Bantustan provinces only. Government reports show that the challenges of inadequate human resources, infrastructure, stewardship and management are also felt across the wider health system. The government's attempts to redress the shortage of health personnel by increasing the intake of training institutions and utilizing training facilities in Cuba to quickly "grow" the capacity are essential and must also be accompanied by efforts to stem the drain of the existing pool of professionals to the private sector or overseas (Health Systems Trust 2013).

Implementing the NHI amid the limitations of the present system will indeed be challenging and the government is correct to focus the first phase of implementation on strengthening the institutional capacity of the public sector. Efforts to strengthen management capacity by providing leadership and management training and courses for hospital chief executives and senior managers are to be welcomed, as is the government's new Academy for Leadership and Management in Health Care in 2012 to address the deficit of public sector management skills and expertise (RSA DoH 2012). Financial as well as non-financial incentive packages (which address workloads, standard of work premises and frequency

of in-service training) to recruit, retain and maintain health professionals (clinical and administrative) should be embedded in workforce planning to prevent the attrition of health professionals in the public sector.

Lastly, while current government efforts to boost management capacity and administrative leadership for local authorities and clinical institutions are important, it will be essential for the government to also address the concerns of frontline clinicians if it is to ensure successful implementation—not least because the performance of the new system will depend on their support and motivation. Evidence from other developing country attempts to introduce universal health care shows that, despite radical reform efforts, many systems largely remain two-tiered, and demonstrates that without a motivated medical workforce efforts to change the system will be ineffective or even counterproductive (Giedion et al. 2013).

Given the likely reliance on the private sector to meet health care needs at least in the immediate term, SA policy makers will need to identify strategies to meaningfully engage and incentivize them to achieve the desired outcomes. Given the entrenched and deep-rooted market culture which presently exists, a key challenge will be to achieve a shift in culture and norms, in particular to instill a more cooperative model of care with patient-centred values. Public and ongoing media "spats" indicate that the government has not yet been able to convince private medical doctors (in particular, GPs) that the NHI scheme is viable, or indeed, in some cases, desirable.[8] Since doctors working in private practice constitute nearly 70 percent of the total number of GPs working in SA, these GPs will need to be convinced of the new proposals if the NHI scheme is to be implemented.

This analysis suggests that the government will face considerable challenges to its proposed reform path, and that the eventual design of the new system may have to be a compromised version of the system envisaged in the original Green Paper. In particular, the government will face significant challenges in garnering the support of sections of the medical profession tasked with implementing the reforms. The challenge to educate, recruit and retain a health professional workforce that can implement the new arrangements under the NHI is a major one and will take a considerable period to establish.

[8] Archer (2014a, b), Kahn (2014), Malan (2014).

Finally, the problem of policy determination (at the national level) being separated from policy implementation (at the provincial level) combined with fiscal federalist budgeting arrangements will continue to pose significant institutional challenges to rolling out the proposed reforms. It highlights the challenges of implementing a universal health care reform agenda when the central state is constitutionally unable to enforce compliance with its policy mandate at the regional level. The ability to achieve universal provision across the country, with patients receiving similar levels of care irrespective of their geographical location, is complex in this context.

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13

Social Policy in Venezuela: Bucking Neoliberalism or Unsustainable Clientelism?

Julia Buxton

Introduction

This chapter examines the social protection policies, or *misiones*, introduced in Venezuela by the government of President Hugo Chávez (1998–2013). Health care is a primary focus, with the chapter contextualizing the government's attempts to develop an integrative model of coverage informed by participatory and social medicine approaches. Three phases of social policy evolution are identified, with the period following a coup attempt against Chávez in 2002 through to the presidential election of December 2006 (phase two) being identified as the most innovative.

It is argued that the achievements were significant, particularly given the national crisis inherited by Chávez, but that health and other welfare initiatives were unsustainable without major institutional and economic policy change. Continuity with a domestic tradition of financing social

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protection with volatile oil export revenues is highlighted. As detailed in the first half of the chapter, oil wealth enabled Venezuela to advance an early and expansive welfare model, but one that was vulnerable to commodity price falls and related fiscal distortions. This was perpetuated by the Chávez government, and with the president's death from cancer in March 2013 and the subsequent narrow victory of his successor Nicolás Maduro, political conditions were not conducive to the reform processes necessary to consolidate the advances made.

Social Protection in Latin America

The literature on Western societies points to the influence of industrialization and democratization on the type of welfare states that emerged.[1] Huber and Stephens identify a "robust relationship" between democracy and social spending (2012: 49) and the importance of the international context in creating conditions favourable to welfare initiatives. Secularism and a viable left-wing political presence are associated with peaceful distributive change. For Navarro and Shi (2001), it is not just the presence of an organized left, but their *capacity* to govern and *willingness* to enact social policy measures when in power that explains the depth of social protection.

The variables influencing the emergence of welfare models in Western Europe's social democracies were absent in Latin America. The region had experienced three hundred years of Iberian Catholic colonization, with local economies configured around the extraction of mineral wealth and agricultural estates. Societies were rural, stratified and religiously observant. Inequalities in the distribution of land and capital assets were compounded after Independence as the USA pursued aggressive economic expansion and commercial interests allied with authoritarian *caudillos* to repress demands for democracy and labour rights (Grandin 2006). With the Cold War and the Cuban Revolution of 1959, the rise of an autonomous political left was curbed by brutal right-wing military interventions that froze reform. The US influence made for an

[1] Esping-Andersen (1999a, b), Cereseto and Waitzkin (1986), Stephens (1979), Pampel and Williamson (1989).

international context antithetical to the introduction of state welfare regimes and Latin America was permeated by the *laissez-faire* ideals of its Northern neighbour.

Despite existence within the US sphere of influence, Latin America experienced infrequent bursts of democracy. Although these were most usually countered by the political right, they marked the introduction of basic protection regimes associated with import-substitution industrialization strategies. According to Muntaner et al. (2006: 20): "Although inefficiently and inequitably stratified into parallel, hierarchical systems, until the end of the 1970s, social services, including health care, expanded in most Latin American countries, aiming at greater social equality."

Contrasting with the Western European experience, these welfare regimes emerged from state-led initiatives to co-opt organized labour. Social protection was not a result of bargaining outcomes but an imposed social contract between the people and a mass, multiclass party such as *Partido Justicialista* in Argentina, the *Partido Revolucionario Institucional* in Mexico and *Acción Democrática* (AD) in Venezuela (Kitschelt and Wilkinson 2007). Advances regressed as the import-substitution industrialization model indicated "exhaustion" and the capacity of the state to maintain public spending commitments deteriorated. Amid popular frustration with the fractured social contract, the military assumed power in most countries and, through a new cycle of repression, guided neoliberal-inspired economic strategies that dismantled the model of state regulation of the economy (Smith and Korzeniewicz 1997).

Rents and Welfare: The Foundations of Venezuelan Social Protection

Venezuela followed this generic trajectory, but with important differences, most specifically relating to the country's status as an oil exporter. Venezuela's hydrocarbon reserves were first exploited during the Juan Vicente Gómez dictatorship (1908–1935) and by 1928 the country was the world's second-largest oil producer (McBeth 2009). However, the income was modest as concessions were granted to private foreign oil companies under the 1910 Mining Code. This only provided for general

taxes—effectively a ground rent (Mommer 1986) and a 7–10 percent royalty on exports.

Three oil-related factors influenced the Venezuelan state to initiate public health provision in the 1930s and as the oil sector contribution to total exports climbed from 28 percent in 1925 to 91 percent in 1935 (Tugwell 1975: 182). According to Tinker Salas (2009), foreign oil companies such as Royal Dutch Shell, Creole (a subsidiary of Standard Oil of New Jersey) and Mene Grande (Gulf Oil) provided a "new economic modernity" of housing, health and education provision in the expansive oil camps that sprang up across Venezuela as the government issued over 4000 concessions before the start of the Second World War. With nearly a quarter of Venezuelans living near the camps, this model of corporate social welfare catalysed demands for a state response to the dualism between the modern oil sector and the backwardness of Venezuelan society (Baptista 1997). Average annual income was USD 147, making Venezuela one of the poorest countries in Latin America. Average life expectancy was 34 years, with preventable diseases including malaria, yellow fever, Chagas disease and cholera the principle cause of death. An estimated 75 percent of the population was illiterate and half were informally employed on landed estates.

Further pressure came from the development of political parties that were crystallized by a new middle class linked to the rentier economy and immigrants from Europe and the Caribbean that swelled the labour sector. Organizations such as AD protested for democracy and labour rights and for better management and conservation of Venezuela's hydrocarbon resources, the benefits of which they argued should be "sown" into national development (Buxton 2001).

Mass urbanization and the spread of infection and disease was another important institutional push. The Ministry of Health and Social Assistance (*Ministerio de Sanidad y Asistencia Social*, MSAS) was established in 1936 with 5 percent of the national budget and a mandate to address disease prevention, health promotion and administer a small number of state-funded hospitals. National institutes and specialized health, hygiene, cancer and therapy divisions were then established between 1936 and 1945 to support preventive medicine. These initiatives halved infant mortality, increased life expectancy to 57 years and reduced incidents of malaria to just triple figures by the mid-1940s.

During a brief democratic interlude known as the *Trienio* (1945–1948), an expansion of social protection was funded by a 77 percent increase in the income per barrel paid to Venezuela following the introduction of a new oil law in 1943. The law set out that concessions would revert to the state after a forty-year period and it established that foreign oil companies could not make greater profits from oil than they paid to the Venezuelan government. An amendment in 1947 introduced 50–50 profit sharing between the state and the oil corporations. This increased the contribution of oil taxes to national revenues from 34.97 percent of income in 1938 to 65.20 percent by 1948 (Toro Hardy 1992: 40).

The 1947 Constitution established for the first time the state's responsibility for public health, with Article 51 setting out curative and preventive obligations and Article 52 outlining the right of citizens to protection from ill health and disease. Building on a framework for social security coverage initiated in 1944 and expanded in 1946 with the creation of the Venezuelan Social Security Institute (*Instituto Venezolano de los Seguros Sociales*, IVSS), the 1947 Constitution required state contributions to a progressive system of social security and it outlined the state's responsibility to provide for the poor. The National Hospital Plan of 1947 had a construction target of 22 hospitals and 48 health centres within a ten-year period, increasing the number of public hospital beds to 9,000 from 610 in 1947 (Kornblith and Maingon 1985: 177).

Oil and Welfare in the Punto Fijo Period 1958–1998

The speed of change during the *Trienio* alienated elite and clerical interests, culminating in a coup d'état in 1948 and a return to military dictatorship. Venezuela resumed the path of "sowing" oil income in social spending in 1958, when the country transitioned to democracy after previously conflictive actors formulated a political consensus through the 1957 Pact of Punto Fijo (Karl 1987). This pact was signed by the leading political parties, AD and its Christian Democrat counterpart the *Comité de Organización Política Electoral Independiente* (COPEI) and representatives from the Catholic Church, the trade union confederation, the

military and the private sector. Central to the agreement was the commitment of the political parties to control the demands of affiliated unions, and the reciprocal acknowledgement by the private sector of state-funded development and social protection measures. The availability of oil revenues meant social policy initiatives were not dependent on income redistribution from wealthier sectors. As a result, Venezuela did not experience a political backlash from the country's elite. Public-financed welfare and generous remuneration for organized labour welded affiliation to the two political parties, in turn stabilizing the new, if illiberal democratic system.

Article 76 of the 1961 Constitution guaranteed that public health care and the MSAS maintained responsibility for the planning and implementation of the national health strategy. Public health provision was seen as a motor of development in the new democratic period, with initial priority given to expanding medical access and vaccination campaigns in rural areas in line with the Agricultural Reform Programme of the first AD government. A total of 436 rural clinics and 124 specialized rehydration centres were constructed and, in conjunction with preventive health initiatives, this increased life expectancy from 53.6 years in 1958 to 59.2 years by 1961. Life expectancy in urban areas improved at a slower 2.5 years, to 65.8 years (Kornblith and Maingon 1985: 180).

By the mid-1960s, the MSAS was responsible for 59 public hospitals with 13,090 beds, while private provision accounted for 2,770 beds. The expansion of the public hospital network improved the ratio of beds to population to 3.5 per 100,000 in 1963, contrasting with 2.9 per 100,000 in 1950 (Kornblith and Maingon 1985: 182). These figures did not include IVSS and military hospitals, the former expanded by the 1966 Social Security Law that increased the number of workers and employers contributing to the obligatory scheme, with a one-third top-up payment by the state, and which extended sickness coverage from short-term illness and pregnancy to long-term incapacity benefits and funeral payments. New and generous social security legislation was introduced in 1967 with *Centro Venezolano de los Seguros Sociales* provision covering approximately one-third of the labour force employed in the formal private and public sector though state, employer and employee contributions (Amparo Cruz-Saco 2002).

The financing of welfare was driven by increases in hydrocarbon receipts and Venezuela was proactive in diplomatic efforts to build the Organization of Petroleum Exporting Countries (OPEC) to raise international oil prices. The country was moving in the direction of oil sector nationalization when the Yom Kippur War and the Middle East oil embargo led to a sixfold increase in the price per barrel of Venezuelan oil, expanding government spending capacity 26 percent per year between 1974 and 1977. Resources were ploughed into: "state-owned, enterprise-led, natural resource-based, big-push heavy industrialization policy … in an attempt to vertically integrate the import-substitution process" (Di John 2009: 177). Domestic demand was stimulated by generous salary and multiple minimum salary increases; an extension of subsidies on transport, rented housing, food and medicines, unemployment insurance and national housing policy contributions; new bonuses for vacations and childcare; and generous labour provisions that included double indemnification for dismissed workers, seniority payments and decrees prohibiting the dismissal of low paid workers.

The government of President Carlos Andrés Pérez (1974–79) decreed the nationalization of the oil sector in 1976 and this positioned the state to capture the financial benefits of the second oil boom of 1981 catalysed by the conflict between Iran and Iraq. According to Moreno and Shelton (2013: 3): "from 1974 to 1985, the increase of oil prices above their 1960–1973 average contributed an additional 523 per cent of 1973 gross domestic product (GDP) to a government that traditionally occupied 18–20 per cent of the economy". This fed down into social expenditures, which increased from 17 percent of the budget in 1962 to 33 percent in 1973.

By the early 1970s, Venezuela was the region's fastest-growing economy and richest country and one of the 20 wealthiest countries in the world. This scenario was transformed by the subsequent fall in world oil prices, which, in addition to domestic economic policy mismanagement, combined to decimate the welfare model and the credibility of the Punto Fijo political system.

Economic Bust and Welfare Decline

Venezuela's oil wealth was reconceptualized as a curse as a result of catastrophic economic demise in the 1980s (Coronil 1997; Karl 1997). The influx of petrodollars bred dependence on easy, yet unpredictable income streams, distorted macroeconomic policy making and fostered corruption and clientelism (Allen 1977; Baptista 1997). Unemployment was an ongoing problem, with the oil sector employing only 2 percent of the economically active population. Between 1970 and 2000, there was a 64 percent fall in per capita oil production as a result of underinvestment in the newly nationalized sector, while per capita fiscal oil revenues fell to one-third of their 1970 level by 1990. There was profound political reticence to reduce public spending. Governments ran down international reserves, devalued the national currency, raided the investment funds of the state oil company *Petróleos de Venezuela SA* (PDVSA) and acquired international debt, which increased from less than 7 percent of GDP in 1975 to almost 35 percent by 1978, climbing to 74 percent by 1989. At this juncture, the welfare state was incapable of providing an adequate safety net and the distortions in previous high levels of welfare state spending became evident.

In health care, diversified lines of responsibility and tributary provision inherited from the authoritarian period were retained and built upon during the economic boom, resulting in a duplication and fragmentation of responsibility between the MSAS, IVSS and the Ministries of Education and Military Social Provision (González 2006; Hellinger and Melcher 1998). This was complicated by the tendency for governments to create off-budget discretionary vehicles for social spending, with the resulting institutional confusion accounting for a rise of preventable disease as the primary cause of infant and adult mortality during the 1970s (Kornblith and Maingon 1985: 187). As lines of accountability for "integrated" health care dissipated, public health and preventive campaigns became uncoordinated. Particularly acute was the sclerosis of the IVSS, which was the centre of corruption scandals in the 1980s and 1990s. Rising unemployment meant a decline in the percentage of the labour force contributing to the health schemes administered by the IVSS, while the number of beneficiaries per contributor increased. The end result was

that by the mid-1990s, the IVSS was unable to cover an estimated one-third of its outlays.

A second problem was public health expenditure patterns, which by the end of the 1960s accounted for 8.6 percent of the national budget. Resources were focused on curative rather than preventive health care, and there had been a surge in investment in expensive capital projects with related recurrent expenditures. This led to a concentration of medical facilities and hospital beds in large urban centres, for example Caracas, where 23.6 percent of hospitals were located by 1978, and Zulia (11.9 percent), to the detriment of health care and disease prevention in rural areas, underscored by the statistic of 40.5 percent of trained doctors being located in Caracas. A further drain on the health budget was salary payments and benefits to organized medical professionals and administrators within the vast bureaucracies of the IVSS, MSAS and health quangos. As investment in preventive, quality and complex health care needs deteriorated during a period of increased social spending in the early 1970s, there was growing demand for private provision, with the sector expanding from 12.4 percent of hospital beds in 1963 to 22.8 percent by 1979 (Kornblith and Maingon 1985: 189) and a rise in out-of-pocket health expenses.

Parallel patterns of poor provision, bureaucratization and privileged salary arrangements were evident in education, which, by 1979, was allocating 38 percent of the budget to further education, even though this accounted for just 7.4 percent of students. By contrast, it was projected that 600,000 children of primary school age, 334,000 children aged between 7 and 12, and 439,000 between 13 and 15 years were outside of the formal education system (Kornblith and Maingon 1985: 119).

Proposals to rationalize social policy floundered amid pressure from AD-affiliated unions on the one hand, and a new generation of pro-market liberals pressing for decentralization of Venezuela's heavily centralized unitary political system on the other. This latter position accorded with that of the international financial institutions, to which Carlos Andrés Pérez was forced to turn for a USD 4.8 billion three-year extended fund facility when he was elected to a second presidential term in 1989, and when approximately 54 percent of Venezuelans were living in extreme or critical poverty and without access to basic medical services.

The Structural Adjustment Experience

The literature on structural adjustment application in Latin America highlights economic growth averaging 3.2 percent in the first half of the 1990s; however, this was not pro-poor growth and per capita incomes remained below the level of the 1970s. There was high unemployment, an increase in informal sector employment from 25 percent of the economically active population in 1980 to 32 percent by 1990, and a decline in average real wages (ECLAC 1993).

In terms of health, Laurell (2000) points to a two-phase process of dismantling public provision, starting with reductions in state funding and the decentralization of service delivery, followed by privatization, the rationale for which was outlined in the 1993 World Bank *World Development Report: Investing in Health.* This addressed the limitations of the state's role in health care, including a lack of capacity to implement policies well and vulnerability to capture by special interest groups (Chap. 3, World Bank 1993). The Executive Summary of the report synthesized the recommendations as "decentralizing government services, promoting competitive procurement practices, fostering greater involvement by nongovernmental and other private organizations, and regulating insurance markets" (World Bank 1993: 36).

Critics argue that the marketization of health was influenced less by popular health needs than the prioritization of debt repayment and transnational corporate interests (Jasso-Aguilar et al. 2004; Muntaner et al. 2006). Homedes and Ugalde (2005: 84) argue: "factors that need to be in place to enable a successful implementation of some components of the reforms", most specifically relating to decentralization and regulatory capacity, were absent, with the result that "multiple abuses and exclusions… [have] been the rule more than the exception". This observation holds for Venezuela's experience.

Economic adjustment aimed to orient Venezuela towards a competitive export economy and reduce the omnipresent state (Tulchin and Bland 1993; Naim 1993). Particularly contentious was the move to part-privatize PDVSA under the *Apertura Petrolera* in the mid-1990s. Lending from the World Bank and the Inter-American Development Bank supported a transition to decentralized private health and insurance provision. The World Bank focused its USD 54 million project on four

of Venezuela's 23 states, impacting on three million users. However, in line with Homedes and Ugalde (2005), Venezuela lacked an enabling environment for decentralization. Andrés Pérez did introduce legislation decentralizing services to state governors, who were to be democratically elected rather than presidentially appointed. This and accompanying reforms to the electoral system were intended to offset growing popular antipathy to AD and COPEI. The measures failed to arrest the crisis of *Puntofijismo*, which was manifest in election abstention, ongoing social protest, two military coup attempts in 1992 and the impeachment of Andrés Pérez in 1993.

Decentralization did not improve the quality of public services (Buxton 2001). The majority of state governors were reluctant to assume responsibility for health and other services given the uncertainty over resourcing, and the World Bank strategy of decentralizing to four "capable" states entrenched inequalities and fragmentation of health provision in an already complex system. Hellinger and Melcher (1998: 16) argue that budget reductions led to the closure of many public health facilities, particularly in rural areas, while the introduction of user fees by state and local governments was "excluding in increasing measure the poor from access to health care". Those sectors of the population with the resources for private health care turned away from the chaos of public provision, so that, by 1997, 73 percent of health expenditures in Venezuela were private. A three-tier system emerged, with the wealthiest travelling to the USA for complex and cosmetic treatments due to the low standard of domestic private provision. Under President Rafael Caldera (1994–1998), the "Caldera Laws" aimed to fully convert the national public health system to one of privately administered medical services, but by 1998, the year of the presidential election that brought Chávez to power, the law had not progressed.

Chávez and the Neoliberal Alternative

The Chávez administration marked a dramatic change in the approach to social protection, and not just in Venezuela. Chávez was the first of a number of left-of-centre presidents to be elected across the hemisphere

in the "Pink Tide" of the 2000s, including in Bolivia, Ecuador, Brazil, Uruguay and Argentina. The new left was a non-traditional agglomeration of social movements and political outsiders; Chávez, for example, was a former lieutenant colonel while Bolivia's Evo Morales was leader of the country's coca growers' union. As such, many of the "new left" presidents lacked the institutional linkages to the labour movement that characterized the social democratic left in Western Europe and the mass parties of Latin America. In a vacuum of functioning and legitimate institutions, these non-traditional actors sought to instrumentalize social change through informal mechanisms that connected to the excluded. While this led to their subsequent characterization (specifically in the case of Chávez) as populist or, at its most intellectually myopic, the "bad" left (Reid 2009; Castenada 2008), the reality of many Latin American countries was that the classical liberal model of functioning parties mediating between an active civil society and insulated state had either failed, been discredited or did not match popular demands for representation and participation. Reconstructing society required bringing the state back into social development through an active leadership connected to an impoverished majority through the language of *el pueblo*. This was a radical proposition in the so-called backyard of the USA, but was supported by recognition in the 2000s that persistent inequality undermined economic growth and democratic citizenship.[2]

Relating to Huber and Stephens (2012) observation on the importance of the international context, the end of the Cold War provided an enabling space for Latin America to engage in innovative thinking on social provision. US capacity to influence the politics of the region, including through the international financial institutions, was diminished as a result of the strengthening of democracy as a global norm (precluding military interventions) and the rise of China and Russia (reducing Latin American dependence on the USA). The Millennium Development Goals and the emergence of human security frameworks, most importantly through the 1992 UN Conference on Environment and Development, contributed to the emergence of a propitious environment for new social policy paradigms. The right to a healthy and productive life was restated

[2] Alesina and Rodrik (1994), ECLAC (2002), UNDP (2004).

at the regional level at the 1995 Pan American Conference on Health and Environment in Sustainable Human Development, with the resulting Pan American Charter on Health requiring states to address popular health needs in line with the Regional Plan of Action.

The importance of the Chávez administration lies in its efforts to translate declaratory principles into practice and to address the political as well as economic causes of inequality. In relation to health, the evolution of policy can be delineated into three phases.

Health and Social Policy Under Chávez: Phase One (1999–2003)

The social panorama inherited by Chávez was one of profound inequality, with the poorest quintile receiving 3 percent of national income while the richest quintile captured 54 percent. Over 60 percent of farmland was owned by just 2 percent of landowners and the country lacked food sovereignty. Half of the economically active population were employed in the informal sector, and just 23 percent had access to the bankrupt social security system. Moreover, oil had fallen to a record low of USD 7 per barrel.

The period between Chávez's inauguration in February 1999 and the launch of the health care *Misión Barrio Adentro* (Into the Neighbourhood) in 2003 did not see any significant innovation. Chávez prioritized redrafting of the nation's constitution. This was intended to create the legal framework for an ambitious project of institutional redesign, including in relation to the state's responsibility to its citizens. Fundamental to this "Bolivarian" vision was the notion of "protagonistic democracy", a routine popular engagement in policy development and implementation. The equalization of access and opportunity was seen to be contingent on full and effective citizenship provided for by an expansive and interventionist rather than slim and remote state (Ellner and Tinker Salas 2007; Smilde and Hellinger 2011).

A new constitution was approved in a December 1999 referendum. Under Article 83, the state had responsibility to implement policies to improve collective social well-being, quality of life and access to health

services, with citizens required to engage in the promotion and defence of public health. In line with this commitment, social expenditure assumed an upward trajectory, as demonstrated in Fig. 13.1. Article 84 mandated the state to administer an integrated, universal, decentralized, participatory and free public health service with guaranteed equity of access, while Article 85 established that the financing of health care was an obligation of the state with revenues raised from taxes, oil income and social security contributions. This Article also detailed the state's responsibility to regulate private as well as public health care and committed the state to training health care professionals. State sovereignty over hydrocarbon resources was set out in the Constitution, with majority PDVSA control of all oil-related activities established in the 2001 Hydrocarbons Law. This rolled back the part privatization of the 1990s and reset Venezuela back towards oil financed social protection strategies.

During this period, the government addressed immediate barriers to health care while new constitutional rights were deliberated. Charges for emergency services in public medical institutions were suspended by presidential decree and the government launched a new Ministry of Health and Social Development (*Ministerio de Salud y Desarrollo Social*,

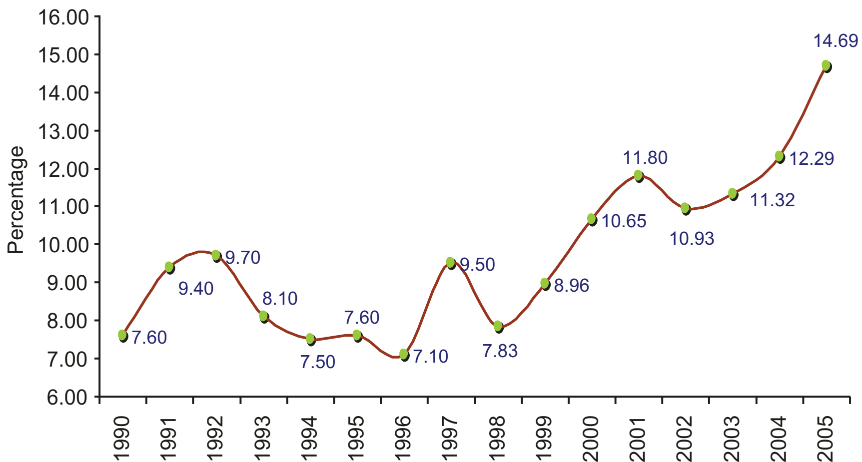

Fig. 13.1 Social expenditure as a percentage of GDP in Venezuela, 1990–2005 (*Source*: Author based on data from Oficina National de Presupuesto (ONAPRE))

MSDS) to replace the MSAS. The MSDS received ordinary resources as well as off-budget revenues from a dedicated social fund, the *Fondo Único Social*, which was financed by windfall oil income. Influential within the MSDS was the social medicine philosophy championed by Chávez's Health Ministers Gilberto Rodrıguez Ochoa (1999) and Maria Lourdes Urbaneja (2001), the former president of the Latin American Social Medicine Association. This critical epidemiology perspective emphasized health as a social and human right to be realized by addressing the political, economic and social determinants of ill health.

The MSDS was immediately engaged in developing strategies to improve access to health care, resulting in the introduction of programmes to update medical equipment in primary health care centres, the drafting of a Model of Integral Health Care and a reorientation of health spending away from curative and back to a preventive focus. The *Plan Estrategico Social* (Social Strategic Plan) of the MSDS, published in 2002, set out the framework for implementing constitutionally guaranteed health care rights.

Reflecting the government's emphasis on integrated provision, initiatives in education included ending the system of half-day primary schooling that was introduced in the 1970s to address the issue of rising student numbers. This led to rapid improvements in the quality of education (Aponte Blank 2012) and was supplemented by the Bolivarian schools programme, an ambitious nationwide project to build and equip 400 schools. However, this only covered one-third of demand. Plan Bolívar-2000, a civil–military programme coordinated by the Ministry of Defence and which was conceived as a "social emergency programme", demonstrated the limited reach of ad hoc approaches. Intended to focus on repairs to the physical infrastructure of the country, Plan Bolívar-2000 was mired in allegations of corruption and claims Chávez was "militarizing" the country.

The traditional political elite in the AD and COPEI parties and their network of affiliated interests resisted the Chávez governments' efforts to create a new Bolivarian Republic, resorting to a coup attempt in April 2002 and paralyzing lockouts and strikes, including at the national oil company PDVSA in early 2003. These actions cost an estimated USD 12 billion in lost oil export revenues and increased the number of households

living below the national poverty line from 44 percent in 1998 to 55 percent in 2003. The political conflicts of this first phase incentivized the radical approach of phase two.

Social Policy Innovation Under Chávez: Phase Two (2003–2006)

Having come close to overthrow, the Chávez administration insulated itself from domestic and international (US) opposition through the adoption of a three-pronged strategy: consolidating its support base among marginalized and excluded sectors; developing new mechanisms to bypass a resistant *Puntofijista* state; and forging new foreign policy alliances. *Misión Barrio Adentro*, the key health care initiative introduced in 2003, represented a drawing together of these three strands in the government's response. It was shaped by the social medicine perspective and the participatory thrust of the Bolivarian revolution.

The roots of *Barrio Adentro* were devastating floods in December 1999 that impacted, in particular, on residents of the informal housing settlements or *barrios* that surround Caracas. The Cuban government provided 454 health care workers through its international solidarity programme. A government request that similar support be provided by the Venezuelan Medical Association was rejected by unionized health staff on security grounds. The Venezuelan Medical Association's subsequent resistance to plans to provide basic health care services in the *barrios* developed by Freddy Bernal, the *chavista* mayor of the Greater Caracas Municipality, led him to negotiate a separate agreement with the Cuban government for the provision of a small number (58) of specialists in family medicine.

The Cubans were initially housed with *barrio* volunteers and from this basis, community-led programmes were established that engaged residents in surveys of local health needs and support to the Cuban medics. The model was adopted by the government with the launch of a nationwide scheme—*Barrio Adentro*—in September 2003. The rollout of the programme was overseen by a presidential commission that drew together health, defence, energy, PDVSA and the MSDS, with traction provided by a cooperation agreement between Venezuela and Cuba that supplied

Venezuela with over 12,000 medics, dentists, integral health specialists and medicines in exchange for 53,000 barrels per day of Venezuelan oil to Cuba.

The initial focus of *Barrio Adentro* was the construction of integrated medical centres or *octogonales* in the *barrios*, providing in situ curative and preventive health care and training for community health workers, of which there were over 2,700 by 2006. This was overseen by 9,000 community health committees organized by *barrio* residents and which included representatives from the MSDS and other institutions critical to holistic health interventions, including the national water company and education, housing and employment ministry officials. The health committees were overlaid onto other participatory initiatives introduced in phase two that were designed to build protagonistic democracy through community-based decision making on issues ranging from education to recreation, infrastructure and housing needs (electricity, potable water, etc.), most significantly the *consejos comunales* (community councils). The councils, which were determined by populations ranging from 250 families in urban areas to 400 in rural localities, were the basis for locating medical centres, and they integrated the community medical committees into their structure and function (MSDS 2005).

The formation of a council medical committee was a prerequisite for the provision of health clinics, engaging communities in the proactive identification of health needs. In contrast to the cost ineffectiveness of locally purchased medical supplies during health service decentralization, all medications were centrally purchased and distributed free of charge by the clinics and a network of popular pharmacies, including antiretroviral drugs and chemotherapy treatments.

From these foundations, *Barrio Adentro* addressed the consolidation of the primary care initiatives through the construction of 6,000 community medical centres and the provision of secondary treatment. This included a target of 600 specialized diagnostic and 400 linked rehabilitation facilities, 35 high-technology centres, the construction of a network of *Barrio Adentro* hospitals including 45 *clínicas populares* (small hospitals with capacity for elective surgery and intensive care), and the training of Venezuelan health professionals. In response to the growing complexity of *Barrio Adentro*, the MSDS was divided into the Ministry of Popular

Participation and Social Development (*Ministerio de Participación Popular y Desarrollo*) and the Ministry of Popular Power for Health (*Ministerio del Poder Popular para la Salud*) in 2005.

Barrio Adentro III, launched in 2006, began the integration of Venezuela's 300 public hospitals into the framework of the health mission, with targets for the construction of 18 specialized cancer treatment centres. *Barrio Adentro IV*, launched at the end of that year, focused on the construction of a dozen hospitals, each with specialist areas of significance to national health needs. By the end of 2006, there were over 23,000 Cuban medics engaged in the delivery of *Barrio Adentro* projects, which covered 68 percent of the Venezuelan population. Initial Pan American Health Organization evaluations indicated a number of positive health outcomes, including reductions in child mortality from diarrhoea and pneumonia, strong community engagement in health projects and a significant and rapid expansion in access to health care.

Paralleling *Barrio Adentro* were other social missions created between 2003 and 2006. These included the education programmes *Misión Sucre*, *Misión Robinson* and *Misión Ribas*; the job creation programme *Misión Vuelven Caras*; *Misión Identidad*, which addressed documentation deficits and electoral registration; and *Misión Mercal*, which provided a network of popular supermarkets providing basic food products at up to 80 percent discounts to ensure all citizens met daily calorific requirements. Additional health initiatives included the 2006 *Misión Milagro* (the Miracle Mission), which focused on ophthalmology and cataract treatment and was introduced after the adult literacy programme *Misión Robinson* identified vision problems as an impediment to literacy. *Misión Sonrisa* (Mission Smile) supplemented the primary care dental services of *Barrio Adentro*, offering access to dental prosthesis through a target of 140 laboratories.

The *misiones* were a means of bypassing politicized and sclerotic bureaucracy while simultaneously canalizing popular demands and the constitutional requirement for participation in decision making. The *misiones* operated as parallel structures that were able to respond quickly to urgent social need through a multisectoral approach. They served as an important linking mechanism to the government's project of building an inclusive "social economy" at the service of need and not profit

through initiatives such as land redistribution and improved popular access to lending facilities. *Misión Mercal*, for example, served as an outlet for the 6,000 agricultural cooperatives planned by the government following the redistribution of land as set out in the 2001 *Ley de Tierras* and implemented at an accelerated pace after 2003. The concept was of a virtuous circle that boosted rural employment, food sovereignty and popular access to low-cost products, which, in turn, improved health and nutrition. Funding for the *misiones* was provided by improved income tax collection and most significantly oil sector revenues, the latter soaring in 2003 and 2004 following the US invasion of Iraq. This linked to the final "outer circle" of the Bolivarian model, which was the reconfiguration of energy and foreign policy.

Having concluded that progressive social change could not be advanced without overcoming conservative resistance, the government assumed an aggressive model of state politicization. The new "People's PDVSA" resulting from the firing of 10,000 staff after the 2003 lockout was integrated into the social economy with the oil company contributing profits and staff to the construction of the social economy. Chávez had come to power committed to diversifying the economy from oil dependence, but, following political confrontation in 2002 and 2003, the oil economy was reconceptualized as the motor of the Bolivarian revolution. New international trade and energy alliances were crafted with non-traditional partners such as China, Russia and Iran, and Venezuela assumed a hawkish position in OPEC. The use of oil as a bartering commodity, as exemplified with the "oil for doctors" programme with Cuba, was extended to Central America and other Caribbean and Latin American countries through regional initiatives such as *Petrocaribe* and *Petrosur*. These projects were driven by the surge in oil export revenues linked to regional integration initiatives that emphasized complementarities over free trade and Latin American unity to the exclusion of the USA, as exemplified by the Union of South American Nations and the Bolivarian Alliance for Latin America.

The integration of these multiple policy strands and their relationship to health and social policy in Venezuela is represented in Fig. 13.2. The commitment to addressing exclusion, poverty and inequality delivered through the *misiones* enabled the government to consolidate its support

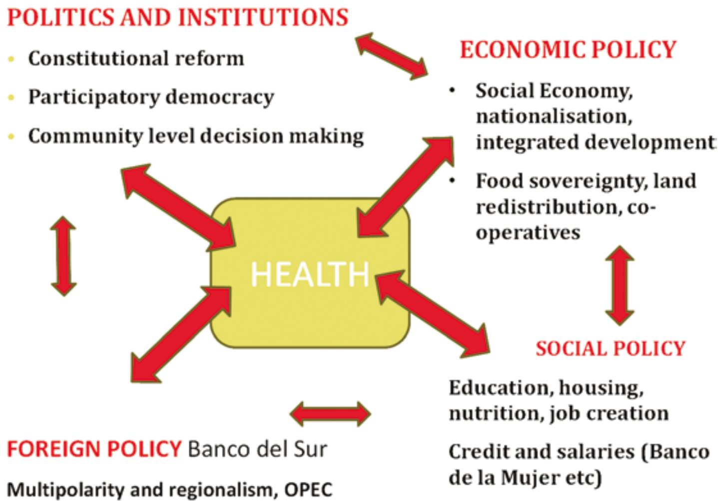

Fig. 13.2 Health policy in twenty-first-century socialism in Venezuela (*Source*: Author)

base, allowing President Chávez to strengthen his position with victory in the December 2006 presidential election.

Neglect and Deterioration

During Chávez's third term (2006–2012) the government reconceptualized the goal of the Bolivarian Revolution as "twenty-first century socialism". Public resources and the government's attention shifted from social protection to socialism in the broader national economy. Having been the primary focus of government activity during the period 2003–2006, social policy slipped down the agenda and emerging dysfunctionalities were not addressed.

A key problem related to reorienting spending and management functions from quantity of provision to quality. This required new mechanisms for specialist input that was not addressed, with the emphasis maintained on non-specialist community participation. This was problematic given evidence of corruption, popular fatigue and increased partisan conflict

in community-level organizations. The Community Councils, of which there were 23,000 by 2006, and linked organizations such as the Health Committees reported problems of non-attendance by the officials that were meant to serve as the channel to ministries. In the context of funding only being provided to organized communities, disaffection and committee dysfunction impeded equity in resource allocation while raising complaints of clientelism and politicization (Pulido de Briceño 2001; Aponte Blank 2012).

A second challenge was the need to institutionalize the *misiones* and integrate these unofficial initiatives with the state bureaucracy that they were designed to bypass. In the absence of a government strategy to unify public service delivery, duplication and mismanagement proliferated and this exacerbated a pre-existing problem of fragmented services that Chávez inherited. A linked problem was a fall in social spending after 2007 as the Venezuelan state assumed expensive responsibilities in other areas of the economy along the lines envisaged by the term "twenty-first-century socialism" and as the international oil price fell back in the global financial crisis. Chávez's third term was marked by an accelerated pace of nationalization, driven by an increasingly assertive pro-Chávez labour sector and as the government responded to blockages in production chains. Nationalization and other interventions such as price and exchange controls contributed to a problem of disequilibrium between economic and social policy. The former began to erode the gains made by the *misiones* by generating inflation, exacerbating shortages and diverting resources into costly subsidies, investment plans and compensation claims.

A final issue that was not confronted by the government was the catastrophic level of insecurity that was particularly suffered by *barrio* residents. The persistent turnover of officials in the interior and justice ministries, the fragmentation of policing and security services and the proliferation of small arms pushed Venezuela up the global league of social violence, with the country ranked number four in world indices of homicide. This environment was wholly antithetical to community engagement and participation and it drained quality of life indicators and health budgets.

After a period of neglect, social policy re-emerged as a government concern in the run-up to the October 2012 presidential elections and as the economy rebounded from a 2007–2010 recession. Over 40 small missions were introduced, but these were limited in coverage and they patched up, rather than holistically addressing, weaknesses in the existing model of social protection. In his campaign for re-election, a physically ailing Chávez acknowledged the need for the "rectification" of the *misiones*, which he set out as the primary objective of a fourth term. Chávez triumphed in October 2012, but his death from cancer in March 2013 left the issue of reform and consolidation under his successor, Nicolás Maduro, open to question.

Conclusion

Two years into his term, Maduro was confronting a grave economic crisis that impacted on health care, including acute shortages of basic and essential medicines, materials and surgical supplies, and the spread of infectious diseases such as chikungunya and dengue. These problems were severe and demonstrate that maintaining a dysfunctional economic strategy, including dependence on oil revenues, rendered social medicine approaches unsustainable. These limitations notwithstanding, the experience of phase two of the Chávez government illustrates that addressing the social determinants of health is a factor of executive commitment and that in situations of political decomposition, "non-traditional" mechanisms can articulate and deliver popular health care needs. Such initiatives, even if only transitional, merit detailed study and should not be written off as merely crude "populist" experiments. The Venezuelan experience points to the importance of moving beyond free market dogma in order to realize social, economic and health rights and, at the same time, reminds us how deeply contested universal provision is in profoundly unequal societies.

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14

Expanding Social Security in Indonesia: The Current Processes and Challenges

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Introduction

In Indonesia, the right to social security is currently enshrined in the Constitution. This forms the social contract between the state and society, aimed at guaranteeing that every Indonesian citizen can live a dignified life. Nevertheless, the road to achieving this objective has been long, difficult and mired with uncertainties. Although most agree with this noble objective, the way to achieve it is controversial, marked by forceful and rigorous debate over how Indonesia should develop its social security system.

For a long time, social security was the privilege of a few. During the three decades of the New Order government from the late 1960s to the late 1990s, social security schemes were reserved only for civil servants and formal private sector employees in medium-sized and large enterprises. A large majority of the population, whose livelihoods were in the

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informal sector, had to rely on informal social protection from their families and communities. When the Asian financial crisis (AFC) struck in the late 1990s, a time when social security was expected to be most useful, Indonesia's social security system proved to be ineffective. A large portion of the population, who had escaped poverty by virtue of three decades of economic growth, remained vulnerable and fell back into poverty.

Once the chaos of the AFC began to stabilize in 2000, reform of the social security system was initiated, resulting in an amendment to the Constitution that adds a clause on the universal right for social security. After a controversial process, viewed by some as less than inclusive, Law No. 40/2004 on the National Social Security System (*Sistem Jaminan Sosial Nasional*, SJSN) was passed near the end of 2004. This new SJSN Law provides a framework for the integration of various social security schemes that already existed and new social security schemes, as well as the expansion of social security coverage to the entire population as mandated by the Constitution.

However, for the law to be operational, various derivative laws and regulations needed to be issued as implementation guidelines. The SJSN Law specified a five-year period for the issue of the derivative laws and regulations. Unfortunately, it was signed into effect just a few months before a new president was to take office. Hence, the derivative laws and regulations became the responsibility of the new government and although it never explicitly stated any objection to the social security law, five years passed without a single derivative law or regulation being issued.

The government was re-elected in 2009 for another five years without a clear prospect for the implementation of the SJSN Law. Hence, the new parliament took the initiative to propose a law on the social security implementing agency. This is a crucial derivative law for the implementation of the SJSN Law. After some protracted deliberations with the government, the parliament passed Law No. 24/2011 on Social Security Implementing Agency (*Badan Penyelenggara Jaminan Sosial*, BPJS) at the end of 2011. The new law created two social security implementing agencies: BPJS Health, which began operation in January 2014, and BPJS Employment, which would begin operation in July 2015.

The establishment of these two social security implementing agencies marked a new era in the development of social security in Indonesia as they are responsible for providing social security benefits to the entire population. BPJS Health is responsible for managing the universal social health insurance, while BPJS Employment is responsible for managing the schemes of pension, old-age, death and work accident benefits.

Short History of Indonesian Economic Development

Post-Independence Period (1945–mid-1960s)

After proclaiming its independence in 1945, the war for independence continued until 1949 when the Dutch government and the international community formally recognized Indonesian sovereignty. The government's focus on ensuring political stability during this period took attention away from economic concerns, leaving the economy weak in the years immediately following independence. From 1949 to 1965, Indonesia recorded some economic growth, predominantly from 1950 to 1957, which was fuelled by two main tradable commodities, oil and rubber, whose prices were rising in the world market. However, the growth shrunk in the period from 1958 to 1965, again due to political instability in the country.

The introduction by Sukarno, Indonesia's first president, of the Guided Economy (*Ekonomi Terpimpin*) regime in 1959, which eliminated all foreign economic control in the private sector, compounded by other surging macroeconomic problems, made economic performance worse than the previous period (Touwen 2008; Lindblad 2010). Booth (1998) estimated a growth rate of per capita gross domestic product (GDP) of only 1 percent annually on average from 1950 to 1965. This growth rate was considered too low for the rapid population growth after the war, which reached 2 percent annually.

New Order Government (1967–1996)

After the New Order government took over in 1967, economic development in Indonesia underwent radical changes. The economy grew rapidly and rose from being one of the poorest countries in the world to a middle-income country by 1993. The per capita income increased from USD 50 in 1967 to USD 610 in 1991, which constitutes an annual GDP per capita growth of 4.6 percent, making Indonesia one of the fastest-growing economies in the world during the period (Suryahadi et al. 2012). The turnaround in the country's economic performance was mainly due to the change in economic policy from a closed to a more open policy.

Initially, the impressive growth also benefited significantly from two oil booms in 1973–1974 and 1978–1979, which significantly raised the government's export earnings and revenues. The increased revenue enabled the public sector to play a greater role in the economy by undertaking substantial public investments in regional, social and infrastructure developments. Increasing foreign exchange also enabled Indonesia to import capital goods and raw material, giving rise to a growing manufacturing sector.

As the oil boom came to an end in the early 1980s, the New Order government redirected the economy from one dependent on oil towards the promotion of the export-oriented manufacturing sector, while the large public investments in education, health, family planning and infrastructure continued. Manufactured exports began to become the engine of the Indonesian economy. During the 1980s, the share of industrial output in GDP was maintained at around 40 percent. In addition to the industrial sector, the share of the services sector's output in total GDP has steadily increased, reaching 39 percent in 1990 (Suryahadi et al. 2012).

The high levels of economic growth during this period resulted in improvements in various social indicators. For example, life expectancy increased from 52 years in 1970 to 62 years in 1990, infant mortality rates fell from 100 per 1000 in 1970 to 54 per 1000 in 1990, school enrolment rates rose from 17 percent in 1970 to 48 percent in 1990 for secondary education and the poverty rate fell from around 40.1 percent

in 1976 to 11.3 percent in 1996. In addition, the provision of basic infrastructure, including health facilities, also rose substantially. For example, the number of health workers increased from 50,000 in 1974 to 190,000 in 1992, working in around 6500 health centres. Furthermore, despite high economic growth sustained for a long period, inequality did not increase. The Gini ratio was relatively stable at around 0.33 (Yumna et al. 2015).

Asian Financial Crisis (1997–1999)

After nearly thirty years of uninterrupted rapid growth, low inflation and a stable currency, the AFC in 1997 reversed the situation completely. The AFC, which began in Thailand, weakened the Indonesian rupiah (IDR) from IDR 2,200 per USD 1 in mid-1997 to IDR 12,000 in 1998. At about the same time, inflation jumped to 78 percent, driven by an increase in the price of food of 118 percent (Suryahadi et al. 2012; Basri 2013). To make matters worse, some areas of Indonesia suffered simultaneously from a severe drought that reduced the harvest of rice, the Indonesians' staple food, as well as other food crops.

The severe crisis quickly eroded confidence in the New Order government, as they were not able to solve the problems fast enough. Demonstrations and widespread calls for President Soeharto to step down took place across the country, with some leading to riots and deaths. By May 1998, the country was suffering from the combined effects of currency, financial, natural, economic and political crises, and Soeharto agreed to step down from the presidency and transferred it to Vice-President B. J. Habibie (Suryahadi et al. 2012).

The skyrocketing price of rice and other basic necessities due to the AFC increased the poverty rate from around 15 percent in mid-1997 to its highest point of around 33 percent at the end of 1998. Around 36 million people fell into absolute poverty due to the crisis, albeit temporarily (Suryahadi et al. 2012). To cushion the impact of the crisis for the poor, the government, with support from donors, launched the Social Safety Net Programme (*Jaring Pengaman Sosial*, JPS) programme, covering food, education, health, employment and community empowerment support.

Post-AFC Period (2000–2007)

During the post-AFC period, the Indonesian economy grew by an annual average rate of 5 percent, or around 70 percent of the average annual growth rate during the pre-crisis period. The services sectors recorded the highest sectoral growth of around 6.5 percent annually, while the industrial sector, which had been one of the drivers of economic growth before the AFC, grew at a slower pace of 3.9 percent annually, and the agriculture sector grew much slower than it did before the crisis, at 3.3 percent annually (Suryahadi et al. 2012). Income per capita rebounded and surpassed the pre-crisis level, inflation decelerated and the exchange rate became relatively stable. The debt-to-GDP ratio declined significantly, from more than 100 to less than 40 percent. Finally, Indonesia regained its middle-income country status in 2003.

As Indonesia slowly recovered from the AFC, the poverty rate began to decline again. The poverty rate fell from 18.2 percent in 2002 to 15.9 percent in 2005. It increased again slightly to 17.8 percent in 2006 due to the increase in fuel prices, but decreased again in 2007 to 16.6 percent. In the post-AFC period, however, the average reduction in the poverty rate is about 0.61 percentage points annually, which constitutes only around 40 percent of the pace of poverty reduction during the pre-crisis period (Suryahadi et al. 2012).

Global Financial Crisis (2008–2009)

About ten years after the AFC, Indonesia faced another crisis in the form of the global financial crisis (GFC). The effects of the GFC were reflected by several indicators, such as the depreciation of exchange rates and the decline in stock market prices. The rupiah exchange rate fell by 30 percent and the stock market index dropped by 50 percent in 2008 (Basri 2013). Nevertheless, the impact of the GFC on the Indonesian economy was relatively mild compared to other countries in the region, including Malaysia, Singapore and Thailand.

The impact of the GFC started to be felt in the fourth quarter of 2008 with a reduction in the demand for Indonesian exports. Export-oriented

industries contracted sharply, with an adverse effect on employment. In the course of just one year, from September 2008 to September 2009, the value of Indonesia's exports dropped by 17.9 percent. The decrease in exports led to a decrease in Indonesia's economic growth. In the fourth quarter of 2008, economic growth slowed to 5.2 percent year-on-year. Still, growth throughout 2008 reached 6.1 percent, which was the third-highest in Asia, after China and India (Basri and Rahardja 2011). In 2009, economic growth fell to 4.5 percent; however, it was still much higher than the global economy, which contracted during the year.

The social impact of the GFC is concentrated in the regions supplying the export commodities. For example, the plantation sector, which supplies the international market, is concentrated in only five provinces, each of which depends on the revenue from a small range of crops, or even just one crop. This, combined with in-place social protection programmes, made it possible for the national poverty rate to continue declining despite the crisis, which affected some regions more than others.

Recent Growth (2010 Onwards)

After successfully weathering the GFC in 2008–2009 as indicated by its ability to maintain relatively high economic growth and poverty reduction, Indonesia continued to post significant rates of economic growth. In 2010, economic growth rebounded to 6.1 percent and this high rate of economic growth was maintained in subsequent years, with the Indonesian economy growing by 6.5, 6.2 and 5.8 percent in 2011, 2012 and 2013, respectively.

As a result of the continuing economic growth post-AFC, the per capita income rose steadily from USD 2,200 in 2000 to USD 3,563 in 2012. Nevertheless, more than 32 million Indonesians still lived below the national poverty line, with approximately the same number of people categorized as the near-poor, who lived only slightly above the poverty line. Furthermore, in contrast with the pre-AFC period, where high economic growth was not accompanied by increasing inequality, the post-AFC growth was in tandem with increasing inequality. The Gini ratio increased significantly from 0.32 in 2000 to 0.41 in 2011, and remained stable in 2012 and 2013 (Yumna et al. 2015).

Development of Social Security in Indonesia

Social Security at the Beginning of the State (1945–mid-1960s)

Most of the modern social security scheme provided by the state did not exist in Indonesia in its early years of independence. The majority of resources were absorbed by the fight for independence and government reconciliations, resulting in low economic growth and high poverty levels. Nevertheless, as in many Asian countries, people had a strong reliance on the traditional support system of the extended family as well as community assistance in times of crises, such as the loss of income because of work termination, illness, old age, disability or death, or even during the process of entering the labour force (Esmara and Tjiptoherijanto 1986).

However, the initial efforts to develop a social security system can be traced back to the basic laws that originated in the old Dutch civil and commercial laws of the nineteenth century. After independence, the first regulation on work accident compensation, covering medical care, invalidity and death benefits, was passed in 1947, and then expanded in 1951. In 1963, the government established two social policy programmes for civil servants: the Civil Servants' Welfare Fund, *Dana Kesejahteraan Pegawai Negeri* (Dasperi), and the Civil Servant Insurance Savings, *Tabungan Asuransi Pegawai Negeri* (Taspen).

Dasperi was a social assistance programme for the families of civil servants, principally compensating for natural disasters, supervised by the Ministry of Social Welfare. Meanwhile, Taspen was a social insurance programme for retired civil servants and their dependents, which aimed to provide retirement benefits for aged civil servants and military personnel and their dependents. A state-owned company, PT Taspen, was established to manage the programme under the supervision of the Ministry of Finance.

The social security programme was extended to the formal private sector in 1964 by the establishment of the Social Security Fund (*Dana Jaminan Sosial*) following the formation of the Foundation of Social Workers in 1957. This programme was voluntary for both employees

and employers and initially covered health-related benefits for employees, such as medical care, maternity and death benefits.

Social Security During the Rapidly Growing Economy (Late 1960s–mid-1990s)

Following the change of government in 1967, the New Order government altered the development priorities of the country. After first successfully managing the political instability, it boosted the economy, resulting in rapid rates of economic growth starting at the beginning of the 1970s, averaging 7 percent annually, until the 1997–1999 AFC brought it to a halt. The period of high economic growth provided room for the government to attempt more advanced public policies, including for social security provision. During the tenure of this regime, the government set economic growth as the fundamental goal and used social policy as an instrument in support of that goal.

New laws and regulations were passed to improve or amend previous regulations. Law No. 11/1969 on Principles of Employment for Civil Servants, for example, combined the previous regulation on civil servants and the military personnel pension programme. This law regulates that retired civil servants receive a monthly pension benefit and a lump-sum old-age savings benefit at retirement age managed by PT Taspen.

In 1971, the pension programme for military personnel was moved to a separate programme called the Indonesian Armed Forces' Social Insurance, *Asuransi Angkatan Bersenjata Republik Indonesia* (Asabri). Asabri was designed to accommodate different pension ages for military personnel and other civil servants. The programme was managed by the state-owned company, Perum (*Perusahaan Umum* or Public Enterprise) Asabri, which was under the supervision of the Ministry of Defence.

The split led the Dasperi programme to a crossroads, since the programme was not an insurance scheme in the ordinary sense, but more a social assistance programme. The government then made the decision to terminate Dasperi in 1975 and transferred the social assistance funds to Taspen and Asabri, while the natural disaster components of Dasperi were handed over to the Ministry of Social Welfare. Government

Regulation No. 25/1981 further merged all social security programmes for civil servants (welfare programme, old-age savings, pensions) into a single programme under the administration of PT Taspen (Esmara and Tjiptoherijanto 1986; ADB 2007). Meanwhile, the social insurance programmes for the armed forces were still managed by Asabri.

A health component programme for civil servants and retired civil servants and military personnel was established in 1968. The programme employed a compulsory contribution managed by the Agency for Health Care Funds (*Badan Penyelenggara Dana Pemeliharaan Kesehatan*) under the supervision of the Ministry of Health (this agency was changed to *Perum Husada Bhakti* in 1984). The target of this social health insurance programme was extended to civil servants, retired civil servants, retired military personnel, and their family members as decreed in 1991. At this stage Perum Husada Bhakti was permitted to run private health insurance on a voluntary basis to expand membership. Its status was changed to a limited liability company (*Perseroan Terbatas* or PT Persero) and became PT *Asuransi Kesehatan* (Askes) in 1992 (ADB 2007).

The voluntary Social Security Fund (*Dana Jaminan Sosial*) programme for private sector employees was replaced by the Employees' Social Insurance (*Asuransi Tenaga Kerja*), which was a compulsory programme. The next substantial development of social insurance for private sector workers was the issue of Law No. 3/1992 on Workers' Social Security, *Jaminan Sosial Tenaga Kerja* (Jamsostek). Government Regulation No. 36/1995, derived from Law No. 3/1992, assigned PT Jamsostek as the implementing agency of Jamsostek. The programme's benefits included health insurance, work accidents, old-age savings and death benefits. The rate of contribution varied from 5.7 percent of the salary for a provident fund, consisting of 3.7 percent employer contribution and 2 percent employee contribution, to 0.3 percent of the salary for a death benefit grant.

Jamsostek was not designed to protect against the risk of unemployment; therefore, it had only a limited ability to cushion the impact of the economic crisis on its participants. In addition, Government Regulation No. 14/1993 regulated an "opt out" mechanism for private sector workers for better private health insurance. This mechanism partly caused the low effective coverage of Jamsostek's health insurance programme. Membership in the programme in 1995, under *Perum Asuransi Tenaga*

Kerja administration, was about 9.1 million workers. It only increased slightly in 1997, when the programme was managed by PT Jamsostek, to 11.8 million workers, which was about one-half of the formal sector employees.

Social Security in the Midst of the AFC and Afterwards

The AFC of 1997–1999 hit Indonesia hard and reversed the positive trends experienced during the previous decades. The currency fell to as low as 15 percent of its pre-crisis value in less than one year, the economy contracted by 13.7 percent in 1998, the inflation rate soared by 78 percent, the unemployment rate increased from 4.7 percent in August 1997 to 5.5 percent in August 1998 and the poverty rate (using a new method of measurement) rose from 17.3 percent in 1996 to 21.4 percent and 23.4 percent in 1998 and 1999, respectively (Suryadarma et al. 2013, Suryahadi et al. 2012).

In spite of the development of a modern social security system prior to the AFC, the system still left a large part of the population uncovered. At this time the system limited its coverage to formal sector workers, whereas about two-thirds of workers were in the informal sector. Even for those who were covered by the system, the scheme did not deliver a sufficient level of income protection or quality of services for the workers and let the workers who were hit by the crisis fall into poverty.

The government's immediate response to the AFC was the introduction of the JPS in 1998 and 1999, which was triggered by the initiation of the Structural Adjustment Programme, in turn heavily influenced by the International Monetary Fund and the World Bank. The Structural Adjustment Programme has four objectives: (i) stabilizing the exchange rate and prices and stimulating domestic demand through fiscal and monetary policy; (ii) bank and corporate restructuring; (iii) improving governance and increasing transparency and efficiency; and (iv) protection for the poor and preservation of human assets, which was accomplished through JPS programmes (Mulyadi 2013).

The JPS programme aimed to prevent the poor from falling more deeply into poverty and to reduce the exposure of vulnerable households

to risk. The programme, which was partly financed by a loan from the World Bank, covers five programmes: a rice subsidy; school scholarships and block grants; health cards (*kartu sehat*), which provide the poor with free access to public health services; a labour-intensive work programme; and the provision of grants to selected community groups (Sumarto et al. 2002).

The JPS programme was an ad hoc response to the crisis. All of its component programmes were plagued by the problems of targeting. A large number of the poor were excluded from the programmes and there was substantial benefit leakage to the non-poor (ODI 2006). There was an acknowledgment among policy makers, mainly in the Ministry of National Development Planning (*Bappenas*) and Coordinating Ministry for People Welfare, for a need to develop a sustainable arrangement to be better prepared for future shocks. Based on this thinking, then President Abdulrahman Wahid started the process of social security reform in 2000 by raising the concept of the development of a national social security system to the Annual Assembly of the People's Consultative Assembly (*Majelis Permusyawaratan Rakyat*), the highest representative body in the country.

In 2002, the Consultative Assembly accepted the proposed reform by amending the Constitution to extend social security to cover the entire population. The amendment of Article 28H, Subsection 3, of the 1945 Constitution asserts that: "Every person shall have the right to social security to develop oneself as a dignified human being"; and Article 34, Subsection 2, states that: "The state shall develop a social security system for all the people and shall empower the vulnerable and poor people in accordance with human dignity." In the original Constitution, none of the articles explicitly mentioned social security. The two closest related articles were Article 27, Subsection 2, which stated that: "Every citizen has the right to work and to live in human dignity"; and Article 34, which stated that: "The poor and destitute children shall be cared for by the State."

A draft concept of the SJSN Law was completed in 2003 and submitted to the parliament in early 2004. The draft had been revised 56 times before it was enacted as Law No. 40/2004 on SJSN in October 2004. One of the major debates in the deliberation process was the decision

over what type of institution would manage the national social security programmes, that is, whether it should be in the form of a state-owned enterprise or a public and non-profit legal entity. The SJSN Law had the consequence of covering the entire population, in both the formal and informal sectors, and bringing them into the national social security system.

The first social health programme that targeted poor households was started in 1994 with the health card programme and was fully institutionalized in 1998 through the JPS Health Programme (*JPS Bidang Kesehatan*), which ran from 1998 to 2001. During 2001–2005, it was replaced by the *PKPS–BBM* programme, which was a fuel price increase compensation scheme that also used the JPS programme management system. The fuel price compensation scheme changed its name in March 2005 to Health Insurance for Poor Households, *Asuransi Kesehatan bagi Keluarga Miskin* (Askeskin) under the first term of President Yudhoyono.[1]

Although the name of the programme referred to a system of health insurance, it was actually a health service fee waiver for the poor that was tax-financed. Askeskin was seen as a first-phase introduction of universal health coverage as mandated by Law No. 40/2004. Like the JPS, the PKPS–BBM and Askeskin programmes were also targeted to poor households. However, Askeskin evolved into the Health Security for Society Programme, *Jaminan Kesehatan Masyarakat* (Jamkesmas), starting in 2008, with the same scope to cover the poor and vulnerable. The difference between the two programmes is the base of participation. Whereas Askeskin was established on a household basis, Jamkesmas is on an individual basis, although its targeting is still done at the household level. In this programme, the Ministry of Health verified the beneficiary list (compiled by Statistics Indonesia—*Badan Pusat Statistik*) and processed the claims, while hospitals and community health centres provided the services and claimed the fees to the Ministry of Health.

[1] While slowly recovering from the impact of the crisis, Indonesia had to deal with the increase in global fuel prices, which had led the government to gradually slash its fuel subsidy, starting in 2005. This resulted in an average of a 30 percent and a 114 percent increase in fuel prices in March and October 2005, respectively. In this period, the social protection schemes were designed to compensate the poor for the impact of the fuel subsidy reduction.

The SJSN Law

As mentioned above, Law No. 40/2004 on SJSN is a framework law. It does not stipulate detailed benefits and contribution rates for each of the programmes (ADB 2007); rather, it outlines the basic structure of the reformed social security system, which is:

- Universal coverage for all Indonesians, both for formal and informal workers and their dependents, who would be required to make contributions to the programme.
- Five separate programmes would be created within the system.
- Four existing state-owned social security companies—Jamsostek, Askes, Taspen and Asabri—would serve as the administrators of the programme.
- A National Social Security Council would be established with 15 members representing the government, employers, workers and experts.
- Formal and informal workers would make different contributions. Formal workers' contributions as a percentage of wages and split between workers and employers. For informal workers, the contributions would be a nominal amount in rupiahs.
- The government would pay the contributions of the poor.

The SJSN Law stipulates five social insurance programmes: (i) pensions; (ii) old-age savings; (iii) health-related benefits; (iv) work accident compensation; and (v) death grants. The details regarding the benefit levels and costs are left to government regulations and presidential decrees. Regarding the institutional setting, the SJSN Law specifies that the four existing state-owned social security companies would form BPJS. Yet the exact role of each institution was to be determined in a separate law.

The SJSN Law required that the regulation on implementing agencies be created by October 2009, five years after it was passed. However, the timeline could not be achieved by the government and the draft of the derivative regulation was not submitted to the parliament by that date. Following this, parliament took the initiative to address the situation by passing Law No. 24/2011 on BPJS in November 2011.

The BPJS Law stipulates two administrative bodies that are responsible for the implementation of the social security programmes: BPJS Health and BPJS Employment. BPJS Health manages the health benefits, while BPJS Employment administers the other four programmes (work accident, old-age savings, pensions and death benefits). Furthermore, the BPJS Law specifies that PT Askes, which previously managed the health insurance of civil servants, would be transformed to become BPJS Health and would start to operate on 1 January 2014. The road map of the national health system (*Jaminan Kesehatan Nasional*) states that the first step of implementation would initially include Askes, Jamsostek and Jamkesmas beneficiaries as the participants of BPJS Health (Widowati 2013).

The BPJS Law also stipulates that PT Jamsostek would be transformed to become BPJS Employment on 1 January 2014 and would start to operate on 1 July 2015 at the latest. The existing health component programme of PT Jamsostek would be merged with BPJS Health; whereas, the social insurance programmes, old-age savings and pensions that are currently handled by PT Taspen and PT Asabri would be merged with BPJS Employment by 2029 at the latest (see Fig. 14.1).

The Nature of Social Security in Indonesia

Social Security Provision

Shared responsibility between all stakeholders, which includes the state, employers, individuals as workers, and families or communities, is a basic concept of social security provision (ADB 2007). In Indonesia, as mentioned in the previous section, informal or traditional support systems from extended families or communities still have a significant role in the provision of support for people (especially those working in informal sectors) in times of crisis. Meanwhile, for formal sectors, there is a strong reliance on the employer's liability provisions and, to a lesser extent, on public and/or private social insurance programmes. Table 14.1 summarizes the existing social insurance programmes for both formal and informal workers in Indonesia.

As of 2009, only 17 percent of the Indonesian population benefited from formal employment-linked contributory social insurance,

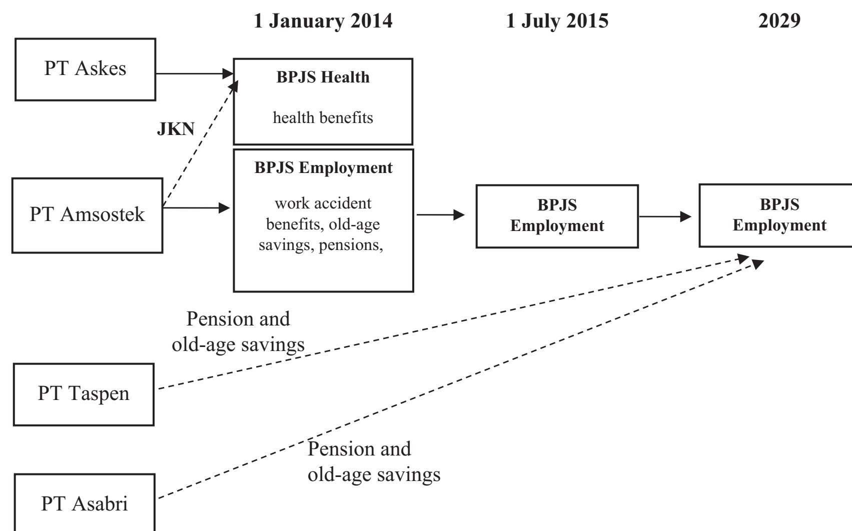

Fig. 14.1 Transformation of BPJS Health and BPJS Employment. *Note*: *JKN* Jaminan Kesehatan Nasional (national health system)
(*Source*: Summarized from Law No. 24/2011 on the Social Security Implementing Agency (BPJS))

Table 14.1 Social Insurance programmes in Indonesia since 2015

	Formal employment		Informal employment*	
Type of benefit	Civil servants	Private sector	Non-poor	Poor
Health	✓	✓	✓	✓
Pension	✓	✓		
Old-age (lump sum)	✓	✓	✓	
Work accident	✓	✓	✓	
Death benefits	✓	✓	✓	
Termination/endowment/severance pay		✓		

* informal employment membership in the national social security system is obligatory by Law. However, there is a phasing in its implementation. The government targets to include formal employment by 2019 and all employment by 2029.

Source: Revised from ADB (2007) and Law No. 24/2011 on BPJS

Table 14.2 Health insurance coverage in Indonesia, 2012

	Coverage (million people)	Percentage of population
Private formal sector (Jamsostek and private health insurance)	23.8	9.83
Civil servants	17.3	7.14
Army and police	2.2	0.91
Informal poor	76.4	31.54
Local health insurance (initiated by district or provincial governments)	32.0	13.21
Total	151.7	62.63

Source: Author based on data from Government of Indonesia (2012).

mostly formal sector employees, according to a study conducted by the International Labour Organization (ILO) and PT Jamsostek (ILO 2010). The social health insurance entitlement showed a better figure, as slightly more than 60 percent of the population is covered by the health benefit programme, of which half is included in the government's health insurance for the poor (Jamkesmas) programme (see Table 14.2).

Social security-related programmes in Indonesia were managed by four social security administrators, which were all state-owned limited liability companies (PT *Persero*): PT Jamsostek, PT Taspen, PT Askes and PT Asabri. These four companies were under the supervision of several ministries as follows:

- The Ministry of Manpower was responsible for the oversight of PT Jamsostek and the enforcement of compliance with its related legislation.
- The Ministry of Finance was responsible for the supervision of PT Taspen, private insurance companies and private pension schemes. It also had some regulatory duties regarding the investment management activities of these limited liability companies.
- The Ministry of Health was responsible for the supervision of PT Askes.
- The Ministry of Defence was responsible for the social security provisions of the armed forces, with PT Asabri administering the scheme.

Health Services Provision

Health services provision is an important component in the implementation of a social security system. In Indonesia, the institutional setting of health service provision involved structural health management at the central, provincial and district levels of government. In addition, the social security system also engages with communities as well as the private sectors (SMERU et al. 2012).

Decentralization in 2001 transferred the responsibility for managing health from the central government to the subnational governments, particularly to the district governments. This had a tremendous impact on the national health system, which was previously predominantly managed by the central government. The subnational governments, particularly at the district level, now have the freedom to develop and plan their own health programmes and activities with their own funds and the funds they receive from the Ministry of Health. Nevertheless, the decentralization arrangements as mandated by Law No. 32/2004 on Regional Autonomy and its derivative regulations still create confusion regarding the role and responsibilities of each level of government, in particular the provincial level, in the health sector.

The central government's role, through the Ministry of Health and the Provincial Health Office to a lesser extent, is more involved with facilitating managerial and cooperative mechanisms among district governments through the provision of technical standards, guidelines, technical assistance and training. For example, the Ministry of Health issued a decree outlining 26 types of minimum public health services with 54 indicators and targets that are to be performed by the district governments. This minimum service standard aimed to ensure that the district governments maintain public health standards and improve monitoring and evaluation processes.

On the other hand, in the decentralization arrangement, the districts are given full authority to prioritize sectors in their development agenda. In some cases, health problems did not receive special attention or funding. Therefore, it is perceived that decentralization has weakened the unified national health system, such as the disease surveillance system (WHO 2008; SMERU et al. 2012).

Health service provision in Indonesia, in fact, is a comprehensive structure from the lowest level at the health post in the village to the referral hospital at the district level. Furthermore, Indonesia has a combination of public and private health services systems. The public health services provide outpatient and inpatient care and also carry out preventive health activities. Meanwhile, the private health services perform ambulatory care provided by private practitioners and government medical staff who work privately (World Bank 2008).

At the district level, there is at least one public hospital that is responsible for providing health services for all of the district's population, with perhaps at least one more private hospital in almost every district in Indonesia. Public health services expanded significantly in the 1970s and 1980s and private services experienced considerable expansion in the 2000s driven by the increase in population, higher disposable income and changing lifestyle, which have opened opportunities for private providers to enter the market.

The total number of hospitals increased from 1,145 in 2000 to 1,721 in 2011, of which more than half (about 52 percent) were provided by private health services. Hospital beds also increased considerably, from 107,537 in 2000 to 148,125 in 2011 (Rokx et al. 2009; IDN MoH 2012). However, the beds to population ratio (beds per 1000) in Indonesia is still the lowest among East Asian and Pacific countries, even compared to those with much lower GDP per capita, such as Cambodia and the Lao People's Democratic Republic (World Bank 2008; Rokx et al. 2009).

At the subdistrict level, there is at least one community health centre (*pusat kesehatan masyarakat* or puskesmas) headed by a doctor or public health specialist and supported by two or more supporting staff such as nurses, midwives or nutritionists. The puskesmas is the backbone of primary health care in Indonesia. The number of puskesmas increased from 7,699 in 2005 to 9,321 in 2011, an average growth rate of 3.5 percent per year in that period.

A common indicator used to measure the coverage of a puskesmas is the size of the population it serves (per 100,000 population). It increased slightly, from 3.61 puskesmas per 100,000 in 2007 to 3.86 in 2011. However, this indicator should be viewed with caution as there could be

a greater ratio for remote areas and sparsely populated areas in the eastern part of Indonesia, such as Papua and Maluku, compared to, for example, the most accessible region of Java. In eastern Indonesia, people have to travel long distances with limited and difficult transportation, as well as considerable cost, to access the puskesmas. This means that the coverage size of a puskesmas is one problem and access is another problem.

The operational activities of a puskesmas are also supported by a sub-puskesmas (*puskesmas pembantu* or pustu) in two or more villages in sub-districts and by mobile health centres (*puskesmas keliling* or pusling). Pustus are mostly headed by nurses or midwives and the services available include basic compulsory health services and community-based health services. The compulsory health services comprise "six basics" covering: (i) health promotion; (ii) environmental health; (iii) maternal and child health (including family planning); (iv) community nutrition improvement; (v) the prevention and eradication of communicable diseases; and (vi) basic medical treatment. Meanwhile, community-based health services are varied by puskesmas depending on the District Health Office's concerns in accordance with the local issues and needs. Services are also dependent on the capabilities of the puskesmas' facility and staff.

At the community level down to the village level and below, health services are provided by the village health post (*pos kesehatan desa* or poskesdes) and the integrated health post (*pos pelayanan terpadu* or posyandu). The poskesdes provides curative services at the village level, while a posyandu provides more preventive and promotive health services. Midwives or nurses usually provide services in a poskesdes, while monthly gatherings in a posyandu are established and managed by the community with assistance from the puskesmas or pustu health staff. By 2011, there were 53,152 poskesdes and 268,439 posyandus in 77,465 villages in Indonesia.

Health workforce density by population in Indonesia is lower than in most countries in the region. Table 14.3 shows that, on average, there are only about three public doctors per 10,000 people, implying that one doctor would need to provide health services for about 3300 people; while the ratio of nurses and midwives is higher, with about 20 nurses and midwives per 10,000 people. This implies that most people seeking medical care will be seen by a nurse or midwife, rather than a doctor.

Table 14.3 Health workforce in Indonesia and other countries in the region

	Doctors		Nurses and midwives	
Country	Number	Density per 10,000 people	Number	Density per 10,000 people
Indonesia	65,722	2.9	465,662	20.4
Cambodia	3393	2.3	11,736	7.9
Vietnam	107,131	12.2	88,025	10.1
India	757,377	6.5	1,146,915	10
Malaysia	25,021	9.4	72,847	27.3

Source: Author based on data from WHO (2012)

Nurses and midwives are distributed much more widely across Indonesia, and are often the only health workers available in remote areas. The higher numbers of midwives are largely due to the Village Midwives Programme (*Bidan di Desa*), which was introduced by the government in 1994, whereby every village was provided with a midwife, resulting in the distribution of this health workforce being much better than other health staff (World Bank 2008).

The lack of a health workforce is not the only problem faced by the poor in rural and remote areas. High rates of absenteeism among health workers is also a serious problem in Indonesia, with one survey in 2003 finding that 40 percent of health workers were absent in primary health centres. This rate was among the highest compared to other countries in the world (Chaudhury et al. 2006). Puskesmas are understaffed, with an insufficient number of doctors and midwives. In many remote rural areas, it is often found that a puskesmas has no doctor available. There is also a question of whether the "legal dual practice" between public and private work of health workers results in their reluctance to provide quality care in their obligatory public services.

The challenges

While the central government has an obligation to implement universal coverage of social security programmes for all Indonesian citizens as mandated by the SJSN Law, some political and technical challenges remain.

Slow Preparation of the Related Regulations

Based on the BPJS Law, the government was expected to have prepared about 16 derivative regulations (both for BPJS Health and BPJS Employment) before 25 November 2012. However, none of those regulations were actually issued by the deadline. The first derivative regulation issued was Government Regulation No. 101/2012 on the beneficiaries for whom the premiums are paid by the government, that is, the poor and near-poor, in December 2012. The second was Presidential Regulation (*Peraturan Presiden*) No. 12/2013 on Health Insurance in January 2013.

The slow process of preparing the derivative regulations has been criticized by the members of parliament and non-governmental organizations as well as academics. This delay has posed some technical difficulties in setting up the institutions and other necessary arrangements related to the implementation of universal coverage, such as the decision on the contributions of participants and governance of initial capital of BPJS. PT Askes, which was a state-owned company and managed the health insurance of civil servants, complained that its preparation to transform itself into BPJS Health, which is a non-profit agency tasked to manage universal health coverage, had been hampered by the delay in issuing regulations.

One of the main reasons for the delay, besides several technical difficulties such as how to appropriately calculate the premium and benefits, is that there are tough and ongoing discussions and negotiations between the government, employees' organizations and labour unions on various issues. For example, even within the labour unions there are opposing positions with regard to the implementation of the SJSN Law. One side has been very active in supporting the SJSN Law on the basis that it is expected to provide social security for all. The other side believes that the universalism of the SJSN Law will actually be detrimental to workers' welfare. They argue that it is the responsibility of the government to provide social security for the people rather than to collect contributions. Under the SJSN Law, workers are now required to contribute 2 percent of their wages for the health insurance scheme, whereas under the previous Jamsostek programme, this had been the responsibility of the employer (Joedadibrata 2012).

Budget Allocation

The government's political commitment to implement universal social security programmes could also be measured by how much of the budget it allocates for the implementation of these policies. Currently, only 2.2 percent of the total government budget is allocated for health. Recent newspaper headlines pointed out that the Ministry of Finance has agreed to allocate only IDR 15,500 per month per beneficiary (equivalent to around USD 1.5) for the poor and near-poor as the premium paid by the government rather than the IDR 22,000 (USD 2.3) proposed by the Ministry of Health. Moreover, this amount would be allocated for only 84.6 million poor and near-poor people instead of the proposed 96.4 million people (the poorest 40 percent of the population) (Jakarta Post 2013).

Health experts have stated that the premium would not be sufficient to cover all types of health problems, which would include catastrophic illnesses such as cancer, diabetes and thalassemia, and would be detrimental to health care in Indonesia. Furthermore, with premiums, it would be difficult for the government to force private hospitals to join the health care programme because they would anticipate difficulty in receiving appropriate compensation for their services. Instead, health experts have stated that in its efforts to provide universal health care, the government should focus its efforts on the provision of state-run hospitals and community health centres (Jakarta Post 2013).

For employment programmes, the government's role in covering poor employees, who are predominantly to be found in the informal sector, is still hotly debated. The issue of the contributions of employers and employees as well as the contribution that should be paid by the government for poor informal employees has not yet been discussed.

Unclear Roles of Local Governments

Indonesia is a decentralized country that consists of 34 provinces and around 500 districts. Health issues (including finance and infrastructure) comprise one of the sectors that have been designated as the responsibility of the district government, with the role of the central government

to steer rather than row. The local health insurance programmes have flourished since 2008. This is directly related to local electoral politics, as candidates promise free social services such as health care and education in a bid to appeal to voters (Aspinall 2014). These schemes were also initiated by many local governments as an effort to reach the poor who were not covered by the central government's Jamkesmas programme.

By 2013, one year before the universal coverage scheme was to be implemented, around 350 local governments (at both provincial and district levels) had a local health insurance scheme in place. However, the role of local governments remains unclear in the grand design of universal health coverage (Harimurti et al. 2013). The BPJS Law, which was enacted in 2011, does not mention the role and responsibilities of ongoing local health insurance. These local schemes, which have variations in benefits packages and reflect in part the fiscal capacity and preferences of local governments, may pose a particular challenge with regard to the harmonization and integration of the universal coverage efforts.

Local governments have felt that they have not been sufficiently informed as to the progress of the universal health coverage plan, what their role will be after universal coverage is implemented and what would become of their ongoing local health insurance. Some local governments went as far as to sue the central government in the Constitutional Court after the SJSN Law was enacted because they believed that it violated the Decentralization Law, particularly with regard to the role of local government in the health sector (Wisnu 2013).

Lack of Hospital Beds

First and foremost, the implementation of universal health coverage may increase the demand for treatment. This phenomenon has already been seen in the Jakarta Province, which launched its universal coverage programme in January 2013. The province, which has more comprehensive health services than any other area in Indonesia, nevertheless struggles with the implementation of universal coverage and found itself overwhelmed by the increased demand for treatment (Fabi and Rizki 2013).

According to the World Health Organization (WHO 2012), Indonesia had only six hospital beds per 10,000 people on average in the period

2005–2011, compared with 42 per 10,000 people in China and 30 per 10,000 in the USA. A critical challenge is the availability of third-class beds/rooms (low-cost inpatient facilities) in hospitals. It is anticipated that this type of bed will be overwhelmed by the increase in demand from poor and near-poor patients whose premiums are paid by the government.

WHO recommendations state that the minimum ratio of third-class beds should be 1:1000 of the population. Indonesia currently has 148,125 beds, both in public and private hospitals (IDN MoH 2012). With a population of 237 million in 2010, there should have been an additional 89,000 beds, with increases over time as the population increases. Currently, the third-class bed occupancy rate is quite high, at 60–80 percent. Furthermore, there is also the issue of service distribution and disparities across regions in the country. The available hospital beds are concentrated in particular areas (mostly in Java), resulting in huge disparities across the country.

Lack of Service Providers

The issue of supply also occurs in terms of the availability and capacity of health service providers. It is apparent that Indonesia faces an acute shortage of doctors. The ratio of doctors in Indonesia is 2.9 per 10,000 people, compared with 14.2 per 10,000 in China and 24.2 per 10,000 in the USA. The *Badan Pusat Statistik*'s Village Potential Data Survey in 2011 reported that around 92 percent of puskesmas had at least one doctor. However, more realistic estimates suggest that as many as 2,250 puskesmas (around 25 percent of the total number) are without doctors, most of these in the more remote areas of the country (Harimurti et al. 2013). Similarly, the distribution of doctors is highly concentrated in the Java-Bali region, which accounts for around 65 percent of all doctors. Fewer than 6 percent of doctors practice in the eastern part of the country.

Lower Quality of Community Health Centres

As mentioned previously, the community health centre (puskesmas) is the backbone of primary health care in Indonesia. Before the passage of the SJSN Law, people were obliged to pay for individual health benefits from

the puskesmas, with the amount to be determined by each local government. The total funds received by a puskesmas became part of the locally derived revenue (*penerimaan asli daerah*) in the local governments' budget. In addition to fees collected from patients, the puskesmas also received funds from a variety of other sources, including PT Askes, PT Jamsostek, Jamkesmas, Jampersal (*Jaminan Persalinan* or Maternity Security) and other government health programmes. With the commencement of the SJSN Law in January 2014, puskesmas financing for individual health efforts has been supported by capitation payments from BPJS Health.

As of 2011, the total number of puskesmas was 9321, comprising 6302 centres with outpatient facilities only and 3019 centres that were equipped with inpatient facilities (IDN MoH 2012). In principle, puskesmas are meant to provide basic health services and referrals to secondary and tertiary public hospitals. However, in practice, many people prefer to go directly to hospitals rather than via a puskesmas. This is mainly due to the low quality of human resources and facilities in a puskesmas. In addition, the gatekeeping and referral functions of a puskesmas are very weak. There are no penalties for self-referring to a higher-level facility, as patients can go directly to secondary or tertiary hospitals to obtain services.

Informal Sector Inclusion

In expanding coverage to achieve universalism in social security programmes, one of the most challenging issues is the expansion of such schemes to cover the non-poor informal sector. Other countries, such as Brazil, China, Mexico and Thailand, have also experienced difficulties covering this particular group. The challenges centre on the level of premium contributions and collection mechanisms. The majority of people in Indonesia (about two-thirds of the population) work in the informal sector, and of these around 50 percent of them work in the agriculture sector and live in rural areas (Harimurti et al. 2013). However, the current system has no coverage for these individuals and households, unless they are considered poor and thus would pay no contribution. The lack of data on this population creates difficulties in deciding the size of the

premium that should be paid and also how such contributions could be collected from the informal non-poor.

Lessons to be learned may be based on the experience of the government's pilot project of the Social Welfare Insurance Programme (*Asuransi Kesejahteran Sosial*). This programme, which has been piloted since 2003 and managed by numerous civil society organizations (CSOs) under the supervision of the Ministry of Social Affairs, targets the poor and near-poor working in the informal economy. The main objective of the programme is to protect informal sector workers by providing insurance in the case of unwanted situations. The programme covers limited health care benefits and death benefits for a maximum membership of three years.

In this pilot project, the workers are encouraged to save IDR 5000 per month for three years and, while they are doing so, the Ministry of Social Affairs bears the cost of any hospitalization that lasts at least five days (up to IDR 1,000,000 per year) and also provides a lump sum of up to IDR 600,000 in the event of their death. It is expected that, after three years, awareness of the importance of insurance would be established and the members would voluntarily join the insurance programme and pay full premiums. In 2012, there were around 125,000 members in the scheme, consisting mostly of self-employed informal workers and managed by 251 CSOs spread over 33 provinces. The lesson to be drawn from this programme is in how it employs the local CSOs in collecting contributions and convincing informal workers to participate in the programme.

Conclusion

Social security provision in Indonesia has evolved from meagre beginnings in the period following independence, to become a privilege enjoyed by formal sector workers during the New Order period, to a system of universal coverage, at least in principle, in the current period. These changes were in line with, and driven by, the developments of the Indonesian economy in general, which has gone through various episodes marked by both booms and crises. Nevertheless, over the long run, there is a clear pattern of expansion in social security provision both in

terms of the schemes provided as well as the population covered by the social security system.

There are two important milestones in the development of social security in Indonesia. The first was the change in government during the chaotic situation in the mid-1960s. The New Order government, after successfully stabilizing the economy, embarked on a policy of economic development, which resulted in rapid economic growth during its three decades in power. The high economic growth during this period made it possible for the private sector to grow and expand, which created a demand for social security for the growing number of workers in the formal sector. Through gradual, successive steps, the government developed various social security schemes, managed by four state-owned enterprises: (i) PT Askes, for managing health insurance for civil servants; (ii) PT Taspen, for managing pensions for civil servants; (iii) PT Asabri, for managing social security schemes for military and police personnel; and (iv) PT Jamsostek, for managing social security schemes for workers in medium and large private enterprises.

The second milestone was the AFC at the end of the 1990s, which caused the downfall of the New Order government. The crisis exposed the weaknesses of the social security system in place at a time when it was most needed. Because it left out a large majority of the population, the social security system was ineffective in preventing a high number of people from falling into poverty. This prompted efforts to establish a stronger social security system in the country, which was initiated by an amendment to the Constitution guaranteeing the right to social security for every citizen. This was followed by the issue of the SJSN Law, which adopts universal coverage for social security provision. After a considerable delay, another law was issued to establish two social security implementing agencies: BPJS Health and BPJS Employment.

However, the challenges for implementing the expansion of social security coverage to the entire population as mandated by the SJSN Law are formidable. Indonesia's vast geography, its huge population and the diverse availability and the quality of the infrastructure mean that the implementation of the national social security system to cover the entire population should proceed very cautiously and involve all stakeholders, including the local governments, employers, employees and the imple-

menting agencies (BPJS Health and BPJS Employment) as well as service providers. For example, in order to avoid confusion, it is important to make sure that the roles of local governments in social security provision are clearly stipulated.

To anticipate the problem of supply-side availability, coordination between various levels of government and multiple agencies needs to be clearly designed. It is also critically important to assess the fiscal sustainability of the system, which requires a degree of political commitment. Since universal coverage would also have an impact on the demand for health care, managing demand shocks, especially during the first stage of implementation, will be very critical, particularly in the health programme. To achieve this aspect, the government needs to develop a clear and strong referral system and make sure that the system works both efficiently and effectively.

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