

Elusive universalism in Latin America's social policy: the long term role of policy architectures in Costa Rica and Uruguay

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Early draft based on a broader project. Please do not quote or distribute

Abstract

Costa Rica and Uruguay have been the most successful cases of state welfare regime in Latin America. They have benefited from high levels of social spending and offered growing benefits for a majority of the population. Historically, however, Costa Rica had a better performance in terms of universal outputs than Uruguay, although in recent years the trends are gradually reverting. How can we explain these different trajectories? In this paper we highlight the role of policy architectures as an explanatory variable. We show that Costa Rica's recent trajectory has increased fragmentation despite long term democracy while Uruguay's has increased unification despite pressures posed by economic globalization. The paper contributes to the conference theme by emphasizing the importance of universal social policies and highlighting the long term role of policy architectures which policy makers tend to assess in terms of their short term implications and mostly for coverage alone.

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1. Introduction

In the last decade, policy proposals aimed at achieving universalism have flourished (ILO, 2011; Molina, 2006) as has far-reaching policy experimentation (Huber and Stephens 2012; Martínez Franzoni and Sánchez-Ancochea, 2014; Pribble, 2013). The term has gained traction among policymakers in national and international institutions: the World Health Organization is pushing for universal health coverage and the United Nations is promoting a global social protection floor. Latin American countries have particularly active in this trend: from Chile all the way to Mexico, different governments have introduced reforms in health care, pensions and other areas in the name of universalism.

But when are social reforms truly pro-universal? And how can Latin American governments that want to pursue them effectively implementing them? Much of the political economy literature links these broad outcomes to the role of democracy (more is better), partisan ideology (the need for strong left-wing political parties) and the influence of collective actors (unions and other social movements). The literature on Latin America has not been an exception, as the recent book by Huber and Stephens (2012) clearly illustrate. Yet are democracy and left-wing parties enough? Now that democracy has consolidated across Latin America, which countries are more and less likely to consolidate universalism? Which are the main challenges to securing it? In this paper we address some of these questions through a comparative historical analysis of Costa Rica and Uruguay, two countries regarded as unique examples of robust social states in Latin America and in the South. Sandbrook et al. (2007) consider the first two as “social-democratic pioneers” and also praise Uruguay for promoting principles of equitable development and generous social policy at different times during the last century. Filgueira (2005: 21) described Costa Rica as “the closest case to an... embryonic social democratic welfare state” in Latin America (Filgueira, 2005: 21) and also placed Uruguay among the few Latin American successes. The two countries are also interesting because, at least when focusing on health care, they have experienced opposite trends in recent decades. While Uruguay traditionally had highly segmented health provision (with different benefits for different groups), Costa Rica developed the most unified and pro-universal health care system in the region. Yet in recent years, Uruguay have succeeded in

promoting pro-universal reforms (Pribble, 2013), while Costa Rica have faced growing difficulties.

While acknowledging the role of democracy as a necessary condition, our main hypothesis is that policy architectures (a concept applied to specific policies and not to interlined social policies at large) are a key independent variable intervening in the relationship between macro-political drivers and universal outputs. At any given point in time the policy architecture determines the extent to which the combination of instruments lead to high coverage, quality/generosity and equity. The policy architecture also influences subsequent policy debates—making pro-universal reforms more or less likely in different contexts. This means that policy architectures not only explain the degree of universal outputs in the short term, but also influence the trajectory of policies over the long term. Understanding the incentives and constraints that the policy architecture creates at specific moments in time will be extremely useful to advance pro-universal agendas in Latin America in the future.

Below we first define what we mean by universalism and then introduce the concept of policy architecture as a useful analytical tool to explore country differences. Then we compare and contrast the evolution of foundational policy architectures in health care services across the two countries.¹ The comparison shows the long term implications that foundational architectures had in each case. Indeed, these two countries undergo opposite trajectories towards further fragmentation and unification in Costa Rica and Uruguay, respectively.

2. The meaning and relevance of universalism

Our first step in discussing and evaluating universalism in Latin America is to define the term. Following Titmus (1958) and Esping-Andersen (1990)'s typology of welfare states, many social policy experts have defined universal social policies as comprising programs funded through general taxation that people receive as a matter of right (Esping Andersen and Korpi, 1987). Everyone should get the same entitlements that are generous enough to ensure people's wellbeing as understood in a given context without resorting to the market

¹ Elsewhere in our work, we also consider the case of pensions as a useful case for comparison. Their incorporation confirms the role of the architecture in shaping social policy trajectories over the long run.

(Huber and Stephens, 2001). Unfortunately implementing these kinds of programs—and their resulting regime—in the South in general and Latin America in particular is full of complications. High income inequality, concentration of political power among a small elite, prevailing informal economies, political instability and macroeconomic volatility have all hindered the creation and expansion of generous tax-based social policy for all (Sandbrook et al, 2007).

Partly as a response to these problems, recent policy proposals rely on “universal” and “universalism” to refer to programs that reach or seek to reach everyone independently of the segmentation in entitlements, quality of provision or funding sources involved.² For example, in the January 2014 speech with which we open this introduction, the World Bank’s president stressed the need for “a special focus on expanding access to vital services for poor women and children.” In Mexico, the much heralded universalization in health care could consolidate different entitlements for those accessing through the contributory and non-contributory systems. Although this effort is presented as a way to reduce inequality, in practice, it may create two-tier social policies that end up separating social groups even more.

In our view, if everyone has access to some health care benefits, but only a few have their cancer treatment covered, there is no universalism to speak of. Neither can we call an education system universal when it combines poor quality public schools, privately managed schools that require co-payments and private schools with more resources, a better curriculum and higher daily school hours for a small minority. When it comes to pensions, if transfers to the poor are below subsistence levels while the rest of the population receives generous pensions based on previous income levels, we may talk about massive coverage yet not about universalism.

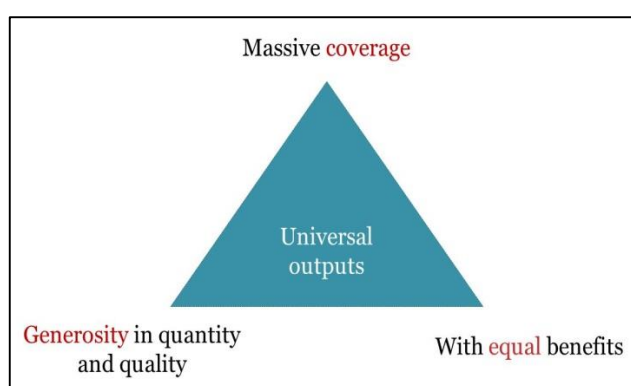
The goal should be to “integrate and include the entire population” with similar entitlements as the Scandinavian welfare state did (Esping-Andersen and Korpi, 1987: 42). Drawing on this definition universalism in the South should entail three dimensions: eligibility criteria; level of coverage; and scope of benefits received. Universal social policies are those that

² “Everyone” may mean the population at large or everybody who is part of a given collective (e.g. young children in the case of pre-primary education or the elderly in the case of pensions).

reach the entire population with similar generous transfers and high quality services (see Figure 1.1), making the resort to markets strictly subject to preferences. These policy outputs can be secured through a combination of different policy instruments (i.e. not only general revenues but also social insurance combined with social assistance).

Figure 1.1

Universal outputs as a triangle of coverage, generosity and equity



Pursuing universal outputs stands in opposition to approaches to social policy that either aim to cover everyone yet with different services, or that target exclusively the poor.³ The need for similar, high quality services and transfers for all highlights the importance of equity in social provision at a time of growing concern about socioeconomic inequalities across the world (OECD; 2011; Wilkinson and Prickett, 2010; World Bank, 2006). Overcoming this situation will certainly demand new regulation in labour markets and property markets. Yet the lack of high quality social policies is also problematic: the levels of income needed for most people to cope with an array of social needs, from education and health to childcare and support at old-age, pushes down the “fragile middle” and creates more obstacles for people at the bottom to move upwards. Only if transfers and services are the same will social policy

³ An additional approach that has historically prevailed in Latin America aimed to incorporate formal workers alone. Fortunately there is now consensus that employment-based access is too limited and that the poor must receive cash transfers and benefit from health care, education and other services.

reduce social, political and economic inequalities simultaneously and enhance notions of belonging and citizenship.

In addition, focusing exclusively on the poor is unlikely to create the type of cross-class coalitions that are required to support a steady growth of social spending (Korpi and Palmer, 1998). When the middle class gains from universal policies, their voice and mobilization capacity benefits low income groups as well. This cross-class alliance is not only helpful to broaden access but also to guarantee one crucial aspect of generosity, namely good quality—the main challenge of social policy delivery in Latin America today. The resulting expansion of transfers and services has substantial redistributive effects and creates a virtuous circle for social incorporation (Huber, 2003). On many occasions, it will be easier and more feasible to deliver services and transfers of similar quality/generosity for all through an array of policy instruments than with single and ambitious programs that are costly and politically difficult to implement.

3. The role of policy architectures

What determines the likelihood of promoting universal outcomes of the type we have just described? In the introduction, we argued that a central mediating factor is the characteristics of the policy architecture. Policy architectures are the combination of policy instruments addressing who access what, when and how: entry, funding, benefits, delivery and outside option. Each components of the policy architecture can be dealt with in very different ways. For instance, funding can be secured by payroll or general taxes and services can be provided publicly or privately. The policy architecture is the blueprint of a program as defined not just by individual instruments but the interaction between the various instruments set in place to cope with each of the five defining components:

- Entry (*Under what conditions can people benefit?*): Entry refers to who is entitled to receive benefits and under what criteria. Citizenship is associated with belonging or residing in a given geo-political state. Insurance may be associated with at least three different status: a paid worker; poor; and dependent family member. From the point of view of universal policy outcomes, ideal eligibility instruments are those that incorporate the highest number of people with as few bureaucratic access barriers as possible.

- Funding (*Who pays and how?*): Funding sources may be general revenues or contributions. The latter may involve government, employers and workers, only employer and workers, or only workers. Any of these funding sources may be complemented by co-payments. From the point of view of universal policy outputs, the more progressive the funding source, the better. Ideally general revenues should draw on direct taxes since value added taxes and other indirect taxes tend to be regressive. In the case of social insurance, state participation should complement contributions from workers and employees and there should also be cross-subsidies between classes.

- Benefits (*Who defines them and how?*): Benefits are generally defined by the state. Possibilities range from lists of everything that is included to exclusionary lists. Ideally, it may be best if the state is the only institution in charge of defining benefits and doing so as comprehensively (but credibly) as possible.

- Provision (*Who does it?*): Providers can be public or private and, if private, for- or not-for-profit. Each of these arrangements is driven by particular goals that may favor or inhibit universal policy outcomes.

- Outside option (*How do governments manage market-based alternatives? Do they limit it or not?*): Outside options refer to the existence of accessible benefit alternatives beyond the public system available only to those who can afford them. The existence of market-based outside options triggers the exiting from state services and transfers, leading to fragmentation (Korpi and Palme, 1998). To reach universal outputs, outside options need to be carefully managed and revolve around optional or complementary benefits. An example in health care is aesthetic surgery. An example in pensions is individual funds going beyond a reasonable replacement rate assured by collective funds.

Policy architectures influence universal outputs both in the short and the long term. In the short-term, they define who receives what benefits and how, thus resulting in different degrees of universal outputs. Over the long-term, by empowering a set of actors and creating a set of incentives for the subsequent expansion of policies, architectures mediate the interaction between democracy and universalism. To consider this dynamic role of policy

architectures, we introduce the concept of foundational architectures: the blueprint of policy instruments set up by states in an initial effort to organize social benefits.⁴

Building universalism does not depend on a given funding mechanism or a single access criterion. Instead, the likelihood of universal outputs depends on how effectively policy architectures cope with fragmentation across policy dimensions. For instance, a country may reach high unification across four out of five components but fail to reach universal outputs due to a robust role of outside market options. Also, a policy architecture granting a small number of services or limited transfers, even if it is done through progressive taxes and public hospitals, is still likely to result in high fragmentation in usage. The implications of a given policy choice for universal outputs need not be assessed in isolation but against the architecture, e.g. payroll taxes versus general revenues. Our argument is that the blueprint of policy instruments set up by states in an initial effort to organize social benefits—what we call the foundational architecture—shapes the subsequent trajectory and the opportunities for universalism.⁵ The more unified the initial architecture was, the easier it was to deliver universal outcomes. The more fragmentation there is, the harder and slower it may be to promote pro-universal reforms. At the same time, however, our explanation is far from deterministic: as the Uruguayan example shows, countries that begin with segmented architectures can gradually move towards more fragmentation under the right incentives.

3. The evolution of the policy architecture in health care

Our comparative analysis of policy architectures in health care show the long term implications of foundational policy architectures, particularly concerning the timing and reach of steps taken toward state-led unification. In Uruguay the foundational architecture

⁴ We ignore initial attempts that may have been exclusively private such as those driven by religious organizations.

⁵ The timing of foundational architectures varies across countries and its identification is more or less straightforward depending on national circumstances. For instance, determining the foundational architecture is relatively easy in Costa Rica: formal arrangements for health care provision emerged with the creation of the social insurance agency in 1941.

was highly fragmented due to the prominence of multiple insurance funds (segmentation) and the active role of private actors (marketization). Such fragmentation took place hand in hand with high coverage yet differentiated entitlements and high inequality. Policy outputs were therefore far from universal.. Policy efforts to unify the architecture were only possible when, following decades of piecemeal change, the state had some central control over all resources in the system.

Since the mid-20th century, Costa Rica has benefited from pro-universalist policy architectures. In Costa Rica, the system was unified across most components of the architecture, even in terms of providers. Social insurance had incentives to incorporate new groups into a unified, state-led sector. In recent years, the state has remained a central provider of services and social insurance continues to incorporate everyone. Unfortunately and contrary to Uruguay, following decisions to cope with the economic crisis of the 1980, the outside option has become a growing problem and threatens to move the country into an increasingly fragmented system.

2.1. Costa Rica⁶

Costa Rica's foundation architecture can be located in 1940 when the first Social-Christian president, Calderón, created social insurance and the CCSS to manage it. The new payroll funded social insurance had three distinctive features contributing to the subsequent expansion of health care (and pensions): (1) it was unified, reaching all workers (and later their families) with the same entitlements, and with a sole, public institution running the system; (2) it first incorporated urban lower income groups and only later, higher income earners (what we call a "bottom-up" expansion)⁷; and (3) from the onset, funding was tripartite with contributions from workers, employers and the government.

These characteristics of the foundational architecture influenced the subsequent expansion of health services, particularly among the non-poor. In the early 1950s, the Caja needed to find

⁶ This section draws on Martínez Franzoni and Sánchez-Ancochea (forthcoming).

⁷ Insurance was initially mandatory for urban workers making up to US\$54.0 monthly wages at the 1941 exchange rate.

a way to increase its legitimacy by expanding coverage (Rosemberg, 1979); to do so, in 1955 it begun incorporating the family dependents of the insured formal workers. Like in the Southern Cone, this vertical expansion benefited groups who already received benefits. Unlike the Southern Cone, the beneficiaries were not upper-middle class professionals but low and lower middle income families who were previously receiving services in low quality, public hospitals.⁸ The change was massive: the first year, the incorporation of family members meant that the Caja served 54% more people than in 1954 - 12% of the total population.

In 1960, the CCSS bureaucrats argued that the combined pressures of growing service demand and governmental debt jeopardized the financial sustainability of social insurance (Rosenberg, 1983). Given the unified character of social insurance, the creation of new social insurance funds that would, for instance, take care of the less wealthy and sicker insured was out of the question. Instead, the CCSS focused on the expansion of the wage ceiling, which affected relatively high-wage earners. In response to these bureaucratic demands, the most socially progressive party in Congress at the time, the PLN, proposed the full elimination of wage ceilings and the universalization of social insurance in 10 years.

Coverage expanded gradually during the 1960s—from 15% of the economically active population in 1960 to 38% in 1970 (Mesa-Lago, 1985)—but funding shortages remained. By the early 1970s, the CCSS bureaucrats demanded the full elimination of wage ceilings to increase revenues and fund the required universalization of the system. In the context of the discussing the budget for 1970 with the management board of the CCSS, the auditor said: "we must insist on the increase in the wage ceiling for the Maternity and Sickness insurance, since this will provide the necessary additional income" and he added that this measure would be significantly more effective than what the government was proposing at the time, namely, transferring taxes on cigarettes that expanded slowly (CCSS, 1969).

⁸ According to Rosemberg (1979) quoting newspapers from the period, the incorporation of family dependents to social security was also a way to confront the problems of overcrowding and insufficient resources among public hospitals to deliver services to the very poor population.

The elimination of the wage ceiling received ample support from the working class. Newspapers reported 18 unions and federations expressing their views to the legislative commission, of which only one opposed the measure.⁹ The influence of the foundational architecture partly explain their support: since the program was built from the bottom up, from the onset Costa Rican workers already insured had incentives to support further expansions to higher income groups that would bring larger tax contributions to the system.

The increase in contributions harmed high wage-earners.¹⁰ At the same time, the fact that social insurance provided high quality services, made their mandatory incorporation to social insurance if not attractive, at least bearable. As the *Caja* built new hospitals, its facilities became the newest and the best funded and equipped. According to the Minister of Health between 1970 and 1974, Jose Luis Orlich, “on the one hand, the Caja has good medical treatment thanks to its great facilities and good personnel, which defines a high-quality medicine. On the other hand, the Ministry has extremely poor facilities [and] deteriorated buildings so that we cannot talk about good medicine”.¹¹ With the removal of wage ceilings and the expansion of mandatory insurance, coverage increased to 55% of the total population in 1975 and 85% in 1980 (Mesa Lago 1985).

During the 1970s, the Costa Rican government also took action to further incorporate the poor to the health care system. While this was partly a response to electoral competition and social pressures (see Chapter 6), reforms implemented were consistent with the unified policy architecture in place. The creation of a primary care program opened the door for the rural poor to access social insurance and receive curative services at the same hospitals than the rest of the population. In 1979, the primary care program was providing services to 717,500 rural people (60% of the rural population) and 120,000 rural poor had become new members of the social insurance and relied on services at clinics and/or hospitals run by the CCSS (Sáenz et.al, 1981). Payroll taxes, which had proved successful in providing sound resources

⁹ March 1971 in *La Nación*, dates 9 to 24 and in *Prensa Libre*, 10 to 26.

¹⁰ An anonymous full-page advertisement estimated that for workers earning above 1000 colones per month, the annual payroll contributions would surpass a monthly salary (*La Hora*, 1970, July 28:3).

¹¹ *La Nación*, 1971, February 24: 57. In 1972, the *Caja* had 1,265 beds and was responsible for 22% of the patients attended compared to 5,984 and 78% in the public hospitals (Audiencia JPS/SJ Comisión de Asuntos Sociales, 11-7-1972 y 13-7-1972 ‘—Doctor Carmona Benavides).

to social insurance over the previous three decades, were also drawn to fund transfers and services for the poor through the Social Development Fund (*Fondo de Desarrollo Social y Asignaciones Familiares*, FODESAF).¹²

By the late 1970s, Costa Rica's policy architecture was the most favorable to universal outputs among our four cases and had developed relatively harmonically. Different types of insurance – contributory and non-contributory; direct and indirect for dependent family members— let everyone access the same health care services. The expansion of facilities among the rural poor further facilitated their incorporation to social insurance. Since then, most components of Costa Rica's architecture have remained intact (Martínez Franzoni and Sánchez-Ancochea, 2013): social insurance is still unified and based on tripartite arrangements and the state plays a central role in running and funding the system and providing services.

Unfortunately, a number of emergency measures confronting the economic crisis of the early 1980s unintentionally opened space for private actors. Access remained high but cutbacks badly hurt the quality of services. Managerial decisions encouraged a large number of physicians to combine private and public practice, which changed their incentives and reduced commitment to the CCSS significantly. By the 1990s, when the fiscal constraints were less pressing, access to social insurance was about the same if not higher than before but generosity and equity had been negatively affected.

The drop in the quality of social insurance services, coupled with a larger and more diversified supply of private services, fuels a growing reliance on outside private options. Between 1991 and 2001, private spending in health care increased by an annual rate of 8% compared to 5% in public spending (Picado, Acuña and Santacruz, 2003). In only five years, between 1993 and 1998, the proportion of out-of-pocket spending for total health care spending increased five times (Herrero and Durán 2001). In the last decade, the share of private spending in total spending increased steadily, from 23.2% in 2000 to 32.6% in 2009. The emergence of a powerful private sector weakens unified services and could eventually

¹² FODESAF was also partly funded with newly created sale taxes.

lead to more radical transformations of the policy architecture (e.g. private administration of payroll taxes and facilities).

2.2 Uruguay

Uruguay's foundational architecture can be traced back to 1910 when the government created the National Public Assistance Board (*Consejo de la Asistencia Pública Nacional*), thus formalizing public sanitation for the poor alone. Meanwhile the middle class relied on a non-regulated non-for-profit outside option based on mutual aid associations¹³ (Setaro, 2013) and the for-profit, out-of pocket outside option was small and available only to the wealthy.

When the state began to worry about health care services for the middle-income population in the early 1940s, this foundational architecture seriously limited its capacity to reach the non-poor. Rather than getting involved in direct service provision, starting in 1943 the government enacted mechanisms to oversee mutual aid societies (Filgueira, 1995).¹⁴ From then onwards, these societies were required to obtain state permits to operate—for example, their governing bodies had to include medical professionals. At the same time, these societies benefitted from fiscal exceptions that honored the social value of the public service they provided.

By the 1940s, Uruguay's architecture was thus highly segmented. First, the poor were set apart from the non-poor and their services were not just different but of a lower quality. Second, since mutual aid societies were pre-paid and relied on fees, both benefits and fees stratified the middle class. In subsequent decades, this architecture helped to expand benefits among the middle class able to pay monthly fees, but did not contribute to standardize the level, quality and equity of services.

¹³ These organizations had begun providing health care services in the mid-19th century, first to their members (usually European migrants) and then to everyone who joined in exchange for a monthly fee. *Asociación Española* (1853); *Sociedad Francesa de Socorros* (1862); *La Fraternidad* (1866); *Círculo Napolitano* (1880), *Círculo Católico de Obreros* (1885); *Centro Asistencial del Sindicato Médico del Uruguay*, CASMU (1935) (Setaro, 2004).

¹⁴ Law 10.384, February 13, 1943. <http://www.parlamento.gub.uy/leyes/AccesoTextoLey.asp?Ley=10384&Anchor=> This legal framework remained untouched until the late 1960s when the state regulated fees.

During the 1970s and 1980s—both under an authoritarian regime and later again under democracy—increased state involvement in health care made arrangements more efficient and less disperse. In the early 1970s, the government mandated that all salaried workers affiliated with a mutual aid association. In 1975, already under authoritarian military rule, the National Direction of Social Insurance (*Dirección de Seguros Sociales por Enfermedad*, DISSE) centralized contributions: each worker made a fixed contribution to a mutual society and the employer and the state paid the rest. The state thus began subsidizing the middle class since “the employee’s contribution, deducted from salary, was considerably less than he/she would have had to pay for individual membership” (Filgueira, 1995:25).¹⁵ In 1979 the National Resource Fund (NRF) was created to fund catastrophic sickness such as kidney transplants and cardiac surgeries for everyone, regardless of whether they were insured or accessed through national public services. Funded with a small share of payroll contributions made by public and private workers (Castiglioni, 2000; Pribble, 2013), the NRF took care of the high cost diseases that could bankrupt small mutual aid societies without affecting their revenues.

In 1987, following democratization, a decentralized public provider (the *Administración de los Servicios de Salud del Estado*, ASSE) was created. The ASSE grouped all public hospitals, clinics and health centers across the country and was funded through general revenues. Access was means-tested and required a free service card. In many ways, this measure was aimed primarily at a managerial reorganization of the public provision. Nevertheless, it also entailed the first attempt to cover the non-poor who did not have easy access to mutual aid societies: many were workers unable to make co-payments and others were spouses and children of workers unable to pay the complementary premiums required (Filgueira, 1995). In 2006, just 20% of the population was under the poverty line, but 40% used the ASSE with many paying a co-payment for it (Ardulo et al, 2012).

These changes made Uruguay’s health care system more efficient and undoubtedly increased the state’s capacity to shape the policy architecture, particularly funding and providers. Yet

¹⁵ Funding came from a 3% of the wages from active and retired workers, a 5% of the wage paid by employers and a complementary contribution made by employers if needed to reach the monthly fee. These contributions were complemented by general revenues (Ardulo et al., 2012).

they did not question the role of mutual aid societies in the architecture; in fact, the creation of the NRF and the growing state subsidies helped in achieving their goals. Moreover, the architecture was still unable to secure the same levels of generosity/quality to all beneficiaries and equity was therefore low. For example, about one million people relied on public hospitals, which received 25% of the total budget devoted to health services, while 1.4 million relied on mutual aid societies which received 75% of all funding, including state subsidies.¹⁶ State subsidies benefited the middle class disproportionately and high co-payments forced many people (even some who were members of mutual societies) to rely on the public sector.¹⁷

A more significant reform of Uruguay's policy architecture took place under the left-wing government of the *Frente Amplio* in 2008. Although ideology and social pressures drove this reform (Pribble, 2013)¹⁸, the previous policy architecture played a double role. On the one hand, it created incentives to introduce changes in the system. On the other hand, it constrained the range of possible options.

The financial pressures for reform were an important incentive. By the second half of the 1990s many mutual aid societies were financially compromised given the rise in health care costs and the need to increasingly rely on state subsidies. The economic crisis of 2001-02 exacerbated the tensions over public subsidies, which were neither enough to contain increasing co-payments nor to assure quality of services. The insured complained about both costs and quality while the non-insured lower income population witnessed the draining of public resources.

¹⁶ In addition, about 250,000 people had access through the military and police force. The total population with access was estimated in 2,650,000 out of 2,900,000 people residing in the country (Filgueira, 1995). The upper class mostly relied on out-of-pocket rather than pre-paid private services (Arbulo et al, 2012).

¹⁷ Price regulation went through various stages. In the 1980s drugs, emergencies and outpatient services had a regulated feed with co-payments aimed at controlling demand. These co-payments became a crucial funding source for providers: in 1992 prices were liberalized – within just two years, drugs, for instance, duplicated their entry copayment – and co-payments extended to many other services. In 1995, the state re-introduced maximum prices and in 2001 prices were lowered for basic medical services (Arbulo et al, 2012).

¹⁸ Promoting health equity was one of the central objectives of the *Frente*. Its ideas reflected a long-term process of conversation and negotiation with key collective actors close to the party, such as those representing medical mutual aid societies and medical professionals (Pérez, 2009).

A further expansion of state subsidies was difficult since the government itself faced a delicate fiscal situation. Withdrawing or reducing state financial involvement would have been rather unpopular – not only among beneficiaries but also among personnel working in the mutual aid societies. Another option was to pursue a more decisive unification of the sector.

Mutual aid societies—a cornerstone of Uruguay’s foundational architecture—thus had a prominent role in making reform possible. First, their financial dependence on state funds created favorable conditions for modifying funding mechanisms. Second, their own diversity as a stakeholder helped the government carry negotiations (Pribble, 2013). Third, the main objective of mutual aid societies was not to increase profits but to protect its membership and its workers, given their character as non-for-profit organizations.

The creation of the National Health System (*Sistema Nacional Integral de Salud*, SNAIS) in 2008 introduced a number of gradual changes (Fuentes, 2013) which had three positive steps towards unification and the incorporation of previously excluded groups. It made insurance mandatory for children and teenagers, to be funded by an increase in premiums and a general subsidy.

Over the counter, direct insurance was eliminated and all revenues channeled to a national health care fund (FONASA) operated by the Social Welfare Bank (*Banco de Provision Social*, BPS). FONASA then transfers resources to providers based on a per capita estimation which considers each person’s age and health risks (therefore increasing equity by pursuing the removal of adverse selection). FONASA pays similar amounts to the mutual societies and the public provider—thus narrowing the historical inequality of the system.

Allocation of resources to providers demands compliance to an Integral Benefit Plan. In 2009 the national authority of the SNS and health care providers agreed on a given number of yearly check-ups for people 65 years of age or more that are free from co-payments (ROU, 2012 in Papadópulos, 2013). Finally, contributions were made more progressive by differentiating monthly fees according to income levels and the presence of children – fees range between 3 and 8% of monthly wages.

The reform clearly enhanced universal outputs, expanding coverage (between 2007 and 2008, 500,000 new beneficiaries were reached by the Integrated National Health System) and equity. Nevertheless, the foundational architecture constrained how far governmental reform efforts can go—signaling its second role in policy change. Measures did not challenge mutual aid societies as main providers of health care services: even proponents of a national health system understood that mutual societies could not be eliminated or subsumed into the public sector (Pribble, 2013). If anything, their role has actually increased as more low-income people can now afford their services. Fewer people joining the public provider translates into fewer resources and a lower chance of improving services. Additionally, opportunities to cross-subsidize public provision from the middle-class to the poor remain low.

Government attempts to have mutual aid societies either provide or contract out emergency services themselves—as part of the services guaranteed by insurance—failed in the face of pressures from already existing independent private providers. Instead, these services remained funded out-of-pocket (Perez, 2009). Unfortunately, this created inequality across different groups of the population.

Funding has also remained more regressive than initially planned. Originally the idea was to rely on a personal income tax which was in the making at about the same time that the health care reform was being negotiated. Yet the government feared that failure to pass the tax reform could also affect the health care agenda and therefore decided to rely exclusively on payroll contributions. A subsequent reform introduced in 2010 set a maximum payroll contribution, making funding even less progressive.¹⁹

4. Conclusions

In the last decade, a growing number of Latin American governments have claimed to pursue pro-universal reforms. Some of them have simply focused on expanding coverage with unequal entitlements—something we have argued is not actually universalism. Other

¹⁹ In principle, each year people should not pay more than the assumed value of the benefit they will receive with an extra margin of 25% (Ardulo et al, 2012). Exceeding contributions will be returned to the insured.

countries like Chile and Uruguay have truly moved towards reforms that cover more people and create similar and increasingly generous services for all.

In this paper, we have shown that the previous architecture will go a long way in determining the extent to which governments will secure universal outcomes. For countries like Brazil where segmentation between the included and excluded was high from the very beginning or El Salvador where the number of the excluded are very high, advancing towards universalism may be difficult. Yet even in those cases, countries will have to focus on their main constraints to develop unified architectures and also in the way to create positive political dynamics over the long run.

The focus on the architecture also helps to explain opposite trends in Costa Rica and Uruguay, countries that have more favourable conditions for universalism. In explaining universalism in both cases and diverse outcomes, democracy may be a necessary condition but by no means sufficient. To explain the causes behind this social policy success in the South there is a striking consensus on the role of democracy. As Sandbrook et al. (2007: 123) state “strong democratic institutions based on a vibrant civil society must develop. These institutions play a pivotal role in motivating politicians to seek equitable socioeconomic development”. The influence of democracy on the social state took place from early on: according to Filgueira (2007: 141), “early social state formation is highly correlated with early democratic experiments.” In Uruguay, social insurance expanded under democratic rule during the 1910s and 1920s. The election of the Colorado party under the leadership of President José Batlle created the opportunity for social legislation and the adoption of new welfare programs (Segura-Ubiergo, 2007). Since then, social policy has expanded as a result of electoral competition, both before and after the democratic breakdown of the 1970s.

In Costa Rica, democracy is also identified as the driver of the social state. In the 1940s, electoral pressures led the newly elected President Calderón Guardia to respond to the “social question” and push for social security (Lehoucq, 2010; Molina, 2008). The later expansion of pensions and health during the 1950s, 60s and 70s has been explained by the dominance of a social-democratic party, the National Liberation Party (*Partido de Liberación Nacional*, PLN), which faced intense electoral competition from conservatives.

There is little doubt that in the two countries democracy has contributed to the expansion of social policy and social incorporation.²⁰ However, while Costa Rica and Uruguay—and some other cases under democratic rule like Argentina and Chile (Sandbrook et al, 2007)—may have high public spending in prominent social programs, they show significant variations in terms of coverage, generosity and, more importantly, equity. Because neither democracy nor other macro-explanations of social policy (e.g. economic growth) are likely to tell us much about this variance in *universal outputs*, we must rely on a different set of explanatory factors.²¹

In this paper we have focused on policy architectures: they do not simply deliver more or less universal outputs at a given point in time, but also influence a country's trajectory over the long term. By picking and choosing who to incorporate first to state benefits and creating different incentives for outside options, they either facilitate or hamper pro-universal reforms. In so doing, architectures reflect and give way to different types of stakeholders which influence subsequent reforms..

To be clear, we are not arguing that policy architectures determine a specific path—that would be too mechanical—or that they are always the most relevant trigger for change—political actors in democratic contexts and international ideas certainly matter. Our argument is that specific features that the initial blueprint of any given social program have strongly influence the timing and likelihood of reaching universal outputs. As a result, when governments across the South introduce new programs, while obviously considering their short term implications, they should give serious consideration to the political dynamics these decisions are likely to create. This is particularly important for emerging policies that are built from scratch like those addressing care.

²⁰ At the same time, the role of democracy, even as a precondition, should not be exaggerated. Consider the case of Costa Rica during the 1940s, the period when key social programs were founded (see also Chapter 5). Costa Rica was then a semi-democracy under constant accusations of electoral fraud (Lehoucq and Molina, 2002).

²¹ State capacity is commonly mentioned as another determinant of social policy success (Evans, 1995, chapter 10; Meisenhelder, 1997; Sandbrook et al, 2007). Yet state capacity does not necessarily explain diversity in universal outputs either: these four countries all had relatively effective states yet more heterogeneous levels of universal outputs.

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