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Social policy architectures and universal outcomes in four countries

J. Martinez Franzoni and D. Sánchez-Ancochea

Abstract

Universalism is back at the center stage of policy making and scholarly work. Despite its growing relevance, in the context of peripheral countries few studies focus on universalism and even fewer investigate how it has come about. While we know that democracy, social movements and left-wing parties (coupled, in some cases, with economic factors) play a role to explain redistributive social policy, redistribution and universalism are distinct policy outcomes. In this paper we address the role of policy architectures as a missing link between democracy and progressive parties, on the one hand, and universal outcomes, on the other hand. To this purpose we compare health care and pensions in Costa Rica, Mauritius, South Korea and Uruguay, four countries that have traditionally been regarded as unique examples of robust social states in the periphery, all four are open economies and the evolution of social policy has been impacted by globalization in diverse ways.

We make two major claims. First, we highlight the diversity of policy architectures and question the idea that any one will by definition be better for universalism than others. Second, we show that fragmentation across components that comprise the architecture constitutes a major threat to universalism in the short as well as in the long run. In particular, the existence of an outside private option can harm achievements in other areas like coverage and generosity. The Costa Rican case stands out among the four cases regarding its ability to promote universal outcomes and avoid fragmentation but also shows the undermining role of the outside option.

1. Introduction

After decades of prevailing residual approaches, countries in the periphery have re-discovered universal social policies (Huber and Stephens, 2012; UNRISD, 2010). Policy

proposals aimed at achieving universalism have flourished (Molina, 2006; ILO, 2011) as has far-reaching policy experimentation (Huber and Stephens, 2012; Martínez Franzoni and Sánchez-Ancochea, 2014; Pribble, 2013). Proposals have spread among policymakers in international institutions: the World Health Organization pushes for universal health coverage; the United Nations has proposed a social protection floor; different Latin American countries have introduced pro-universal reforms. The growing attention to universal coverage and to equitable delivery of social services in debates around the post-Millennium Development Goals has expanded the interest on universalism even further (Fischer, 2012). Such an intense policy debates and policy formation has directly reflected in increasing scholarly work on this matter (e.g., Huber and Stephens, 2012; Krishna, 2010; Pribble, 2013).

Although some of these new approaches build on a narrow definition of universalism based primarily on coverage, much of the social policy literature has defined it as a situation in which everyone receives similar entitlements that are generous enough to ensure their wellbeing without resorting to the market (Esping-Andersen and Korpi, 1987). Drawing on this definition we argue that the analysis of universalism in the periphery must focus on three dimensions: coverage, generosity/quality and equity. Universal social policies are those that reach the entire population with similar generous transfers and high quality services.[1]

Universalism understood in these terms has at least three advantages over other approaches to social rights (Mkandawire, 2006). First, it highlights the role of equity in the provision of services at a time of growing concern about income distribution across the world (OECD; 2011; Wilkinson and Prickett, 2010; World Bank, 2006). Second, the middle class is more likely to support services and transfers they benefit from (Korpi and Palme, 1998). When the middle class gains from universal policies, their voice and mobilization capacity benefits low income groups as well. Third, this cross-class alliance is not only helpful to broaden access to state policy but to guarantee good quality—the main challenge of social policy delivery in many parts of the periphery today. The resulting expansion of transfers and services has

[1] In using this definition, we stay away from conflating universalism with specific policy instruments (such as general taxes). What matters is how policy instruments keep fragmentation to a minimum and not the policy instruments in and of themselves.

substantial redistributive effects and creates a virtuous circle for social incorporation (Huber, 2003).

Universalism may be important, but how can these policies be built in the periphery? Much of the political economy literature answers this question by focusing on a small number of "star" countries that managed to establish large social states and accomplished wide levels of social incorporation.[2] The literature then links these broad outcomes to the role of democracy (the more, the better), partisan ideology (the need for strong left-wing political parties) and the influence of collective actors (unions and other social movements).

Yet these macro-explanations miss important pieces of the story. On the one hand, they downplay the diverse ways in which pro-universal policies have been pursued and the significant problems that even these "successful" cases have faced to reach and sustain universal outcomes. On the other hand, democracy and political ideology may be important preconditions yet cannot explain why universal policies are shaped in certain ways and how they evolve over time. Democratic pressures may, for instance, trigger higher spending in health services for the poor, but do not determine the selection of funding sources and means to deliver services, nor whether benefits set the poor apart from the non-poor.

In this paper we focus on the role of policy architectures as an analytic device to study pro-universal policies in the periphery. We define policy architectures as the combination of policy instruments regarding entry, funding, benefits, delivery and "outside" options of specific social programs. The policy architecture is the blueprint of a program as defined not just by each single instrument but by the interaction between various instruments set in place to cope with each of the five defining components.

Architectures influence universal outcomes both in the short and the long run. In the short-term, they define how, what benefits people receive, how they are delivered and who receives them, thus resulting in different degrees of universal outcomes. Over the long-run, by empowering a set of actors and creating a set of incentives for the subsequent expansion of

[2] While case studies are sometimes accompanied by cross-country regression analysis, econometric studies tend to focus on the level and composition of social policy rather than on universalism per se. See, for example, Huber and Stephens (2012) or Segura-Ubiergo (2007).

policies, architectures mediate the interaction between democracy and universalism (a point we discuss elsewhere).

In this paper we focus exclusively in the short run. We look at countries with robust social policies to explore the diversity of architectures and how they currently and distinctively constrain universal outcomes. We study the cases of Costa Rica, Mauritius, South Korea and Uruguay—all considered successful cases of social development (Huber and Stephens, 2012; McGuire, 2010; Sandbrook et al, 2007; Ringen et al, 2011). Although we are interested in the overall social policy regime, we focus on health care as one of the social services with highest impact on inequality and social cohesion; usually the first or second most prominent sector in terms of social spending (either along education or pensions, depending on the country) and one were past and present debates on universalism have been particularly prominent (Martínez Franzoni and Sánchez-Ancochea, 2014). We test the relevance of our primary findings by investigating pensions as a "shadow case"—following Pribble (2013)'s methodology.

Through this analytical comparison, we make three main claims. First, we highlight the diversity of policy architectures and question the idea that *by definition* one will do better in terms of universalism than others. Much of the social policy literature argues that countries should do their best to emulate the type of policies that the Scandinavian countries implemented over the second half of the 20th century: citizen-based social programs for all based on general taxes (Huber, 2002). Yet the "Scandinavian architecture" may not deliver the expected results and sometimes social insurance may perform as well if not better.

Second, we show the importance of studying the interrelation between different instruments – i.e. the architecture - to explain the obstacles to reach universalism. Although these obstacles show cross national variations that reflect the nuances of each case, they are in most cases driven by the lack of unification across policy components. It is obviously easier to produce universal outcomes when everyone enters a single social program in a similar fashion and when the state plays a major role in ordering the sector, acting as direct provider and taming the market. We will highlight this point by considering Costa Rica's positive performance.

Third, the outside market option plays a prominent role in limiting universal outcomes. Having powerful outside options undermines the likelihood that the other four policy components will manage to deliver *equal*, high quality services for the whole population.

This is made clear by the cases of Mauritius and South Korea where, under starkly different architectures, universalism has been inhibited by the presence of a powerful private sector.

Below we justify our four cases as contemporary successes in social policy provision in the periphery. We then introduce the concept of policy architecture as a useful analytical took to explore country differences. In section 4, we compare and contrast policy architectures in health care services across the four countries. Three of them rely on social insurance with contributions from workers, employers and governments. We highlight Costa Rica's success at promoting a unified system, and speculate about its potential positive effect in terms of universal outcomes. We contrast our conclusions with the shadow case of pensions.

2. Four "star" cases

Costa Rica, Mauritius, Uruguay and, more recently and to a lesser extent, South Korea, have traditionally been regarded as unique examples of robust social states in the periphery.[3] 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. Although South Korea was an exclusionary, authoritarian regime for decades, it is now "indisputably" a welfare state, which has come "about gradually from selective to inclusive protection" (Ringen et al, 2011: 5).

Considered "the closest case to an... embryonic social democratic welfare state" in Latin America (Filgueira, 2005: 21), Costa Rica has long been praised for its success in expanding, health, education and other social services. Between 1940 and 1980, per capita spending in real terms multiplied by three in the health sector and by eight in education (Trejos, 1991) and between 1950 and 1990, the number of physicians per 1000 people went from 3.1 to 7.8 and those of nurses and teachers also expanded rapidly. Welfare efforts covered a growing number of the population: by the 1970s, enrolment rates in primary and secondary education were high and the country did better in terms of human development than almost any other

[3] When the architectures we discuss in here were being set in place, all four of these countries had a relatively low GDP per capita (in 1960 Uruguay's GDP per capita in dollars of 2005 was 3,151, Costa Rica 1,842 and South Korea 1,467) (World Development Indicators). Comparative data for Mauritius is not available until 1976.

country at a similar level of income per capita (Martínez Franzoni and Sánchez-Ancochea, 2013). Today Costa Rica is still praised for its prominent attention to spending in public education and health care.

Regarded as “Paradise Island” (Carroll and Carroll, 2000) Mauritius is clearly an exceptional case in Africa. High economic growth during the 1970s and 1980s generated the resources required to create a redistributive social model. Successive administrations “invested heavily in health care and education; and it subsidised basic foods” (Carroll and Carroll, 2000: 29). The first government after independence granted free education to all citizens and human capital accumulated rapidly (Frankel, 2010). Although a deep economic crisis in the early 1980s forced Mauritius to request support from the International Monetary Fund (IMF) and the World Bank, welfare spending was protected. International institutions “demanded the abolition of free education and free health but Mauritius resisted the pressure and continued to provide these services for free” (Bunwaree, 2005: 7). Coverage continued to grow rapidly: between 1980 and 1997, for example, the primary enrolment rate increased from 93% to 107% and attendance in secondary school remained higher than in most other African countries. Despite growing tensions and difficulties in the last fifteen years, by 2013 a “largely untargeted social protection system plays an important role in securing favorable outcomes for combating poverty and inequality” (David and Petri, 2013: 4). Mauritius has also been recognised for its strong state institutions (Lange, 2003) and the creation of non-contributory social assistance for the whole population (Seekings, 2011; Willmore, 2006).

Despite its unequal features (particularly, the existence of different insurance schemes for different groups of workers as discussed by Mesa Lago, 1978), Uruguay’s “comprehensive social-welfare system” has often been praised (Haggard and Kauffman, 2008). Primary education was mandatory and free from the late 19th century and secondary education and university education expanded steadily in the 20th century (Filgueira, 1995). By the 1970s, Uruguay had developed one of the most generous social states in Latin America and, by extension, in the periphery as a whole (Huber and Stephens, 2012). Benefits went beyond health and education, and since the 1950s included “a great expansion of pensions, the introduction of family allowances, the establishment of the first unemployment-compensation programs, and mandatory compensation in case of occupational accidents” (Segura-Ubiergo, 2007: 59). Although the development of the social state stagnated during the conservative

dictatorship of the 1970s, it has witnessed a rebirth in the last decade with the deepening of a right-based approach in health, education and social protection (Pribble, 2013).

South Korea was for decades the antithesis of an ambitious welfare state active in the delivery of social services. Until the late 1980s, social spending was low and primarily focused on primary and secondary education. Between 1973 and 2000, social spending as percentage of GDP averaged 4.3%—less than a third than in Costa Rica or Uruguay (Martínez Franzoni and Sánchez-Ancochea, 2013). Not surprisingly, the ILO (2007: 17) warned of "under-investment in social protection" in Korea and other Asian countries. This was particularly clear in the case of pensions, which were provided through firm-based schemes. They benefitted a relatively small share of the population and were implemented along an underdeveloped public safety net (Goodman and Peng, 1996).

Yet the situation has begun to change dramatically since 1990 as significant reforms have been introduced in health, pensions, unemployment benefits and social assistance. Public social spending as percentage of GDP more than tripled between 1990 and 2012 from just 2.8% to 9.3%.[4] Benefit expansion has been particularly impressive in health care: "compared to Germany's 127 years, Belgium's 118, Israel's 84, Austria's 79, Luxembourg's 72, and Japan's 36 years, Korea achieved the feat of providing health insurance for the entire population in just 12 years, which is faster than any other country in the world" (Kim and Lee, 2010) Although Korea is still far from a European welfare state, the speed and ambition of the changes have been impressive (Kim, 2006; Hwang, 2012).

In all four countries robust social policies have reflected in high levels of human development. Table 3.1 reports data on infant mortality and life expectancy and adds GDP as a control variable. Differences in social dimensions are lower than in income partly due to a well-known convergence in health indicators—which also have significant upward limits. Yet thet fact that South Korea has a GDP per capita that at least three times higher than the other three countries yet has social indicators that are only slightly better than the rest, also points to the cross-national prominence of social policy. Infant mortality under 5 years of age

[4] Data from the OECD electronic database at http://stats.oecd.org/Index.aspx?DataSetCode=SOCX_AGG (last accessed 21 March 2014).

is below 13 per thousand in all cases, lower than the world average (35) and lower than the average for upper middle income countries (16). Performance in life expectancy is also impressive in comparative perspective and particularly noteworthy in the Costa Rican case.

Table 3.1 Human Development Indicators, 2012

Indicators, 2012	Costa Rica	South Korea	Mauritius	Uruguay	Upper-middle income	World
Infant mortality age 1 per 1000 live births	9	3	13	6	16	35
Infant mortality under 5 years of age	10	4	15	7	20	48
Life expectancy at birth	79	81	73	77	74	71
GNP per capita (2000 US dollars)	5,716	21,562	6,496	7,497	4,315	7,732

Source: World Development Indicators, 2013.

How have these countries managed these achievements, so elusive elsewhere? To explain the causes behind this social policy success in the periphery there has been a striking consensus on the role of democracy. As Sandbrook et al (2007: 123) put it, “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 the dictatorship in the 1970s and after.

In Costa Rica, a country we will discuss with much more detail in the second part of the book, democracy has also been 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.

According to authors like Carroll and Carroll (2000), Seekings (2011) and Meisenhelder (1997), the gradual emergence of democratic institutions even before independence also explains generous social programs in Mauritius. Elections not only forced colonial governments and later nationalist elites to be more responsive to a majority of the population, but also consolidated the long-term influence of left-wing coalitions. More recently, electoral pressures have forced governments to maintain entitlements and, in some cases even to backtrack on regressive reform attempts.

According to proponents of the democratic explanation, its contribution to expansionary social policy is even clearer in the case of South Korea. During the 1960s and 70s, the absence of democracy and the persecution of trade unions and social movements was a key factor behind the lack of social rights (Deyo, 1989). Democratization in the 1980s gave more room to left-wing parties and progressive social movements, and created new pressures to expand social spending (Kwon, 2007). As Haggard and Kauffman (2008: 256) shows when studying not only South Korea but also Taiwan, Thailand and the Philippines, "parties and politicians scrambled to position themselves with respect to pressing social policy issues, from pensions and health insurance to unemployment, social assistance and rural poverty."

There is little doubt that democracy has contributed to the expansion of social policy and social incorporation in these cases.[5] However, while Costa Rica, Mauritius, South Korea and Uruguay—and some other democratic societies like Argentina, Chile or the state of Kerala in

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[5] At the same time, the role of democracy even as a precondition should not be exaggerated. Take the case of Costa Rica during the 1940s, when some key social programs were founded (Martínez Franzoni and Sánchez-Ancochea, forthcoming). Costa Rica was then a semi-democracy under constant accusations of electoral fraud (Lehoucq and Molina, 2002).

India (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 such as economic growth are likely to tell us much about this variance in *universal outcomes*, we must rely on a different set of explanatory factors. [6]

3. The role of policy architectures

We face the challenge of exploring missing links between democracy, social policy and universalism. To this purpose, the concept of policy architecture can be an effective analytical devise. Any policy architecture plays two different roles in influencing universal outcomes in specific contexts: (a) Statically, different combination of policy instruments deliver different levels of universalism understood in terms of access, generosity and equity; and (b) Dynamically, different architectures create distinct opportunities and constraints for subsequent expansion—some of which will be more universal than others. In the rest of this paper, we focus exclusively on the first role.

Policy architectures involve five main components: entry, funding, benefits, delivery and outside option. Each of these components 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. Let us define each dimension:

a. Entry (*under what conditions can people benefit?*). Refers to who is entitled to receive benefits and in light of what criteria. Citizenship is associated with belonging or residing in a given community. Insurance may be associated to at least three different status: as a paid worker; as poor; and as a 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 little bureaucratic access barriers as possible.

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[6] 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 outcomes either: these four countries all had relatively effective states yet more heterogeneous levels of universal outcomes.

b. 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 just workers. Any of these funding sources may be complemented by co-payments. From the point of view of universal policy outcomes, 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.

c. Benefits (*who defines then 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 it if does so in as comprehensive (but credible) way as possible.

d. 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.

e. Management of the outside option (*do governments expand and limit market-based alternatives*?). Outside options refer to the existence of alternatives to access benefits outside the public system, which are only available for those who can afford them. The existence of market-based outside options triggers exiting from state services and transfers and leads to fragmentation (Korpi and Palme, 1998). This is why, to reach universal outcomes, outside options should be carefully managed and revolve around optional or complementary benefits. In health care one example is aesthetic surgery; in pensions, individual funds that go way beyond a reasonable replacement rate assured by collective funds.

We argue that building universalism does not depend on a given funding mechanism or a single access criterion. Instead, the likelihood of universal outcomes 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 outcomes due to a robust role of outside market options. Also, an architecture that grants a small number of services or limited transfers, even if it does it 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 outcomes– say payroll taxes versus general revenues -should thus not be assessed in isolation but against the architecture.

In academic and policy debates, the well spread notion is that Scandinavian countries provide the most desirable road towards universalism (Beland et al, 2014; Huber, 2002). Drawing on the components just discussed, Scandinavian countries have secured universal outcomes through a policy architecture that reached everybody as citizens; granted generous and high quality benefits funded by general revenues; had the state as both setter of benefits and provider; and kept private provision in check.

Yet, in practice, it is not clear whether Scandinavian-like arrangements have succeeded in promoting universalism in many peripheral countries. When poorly funded, services for all have ultimately been used by the poor alone, run short of funding and provide limited and low quality services.

Expanding taxes to provide better services for all—the Scandinavian ultimate solution to secure equity and high quality—has proven particularly difficult in many parts of the periphery. Is thus the Scandinavian architecture the only way to build universalism? Or else, can universalism be reached through a different combination of policy instruments? As we will illustrate now with specific examples, universal outcomes can also be reached through policy architectures based on either social insurance or payroll taxes.

3. Health policy architectures

We now return to our "star" cases and establish the extent to which universal outcomes are secured through a comparative study of their policy architecture in health care. A comparison of cross-national health care arrangements also sheds light on the challenges that each country faces—i.e. where the binding constraints are. In undertaking this comparison, we will demonstrate the importance of state-driven unification across the key components that make up policy architectures.

Table 3.1 describes the policy architecture in each of the five countries. Although there are differences in all components, four are the most significant. Regarding **access**, only Mauritius pursues the expansion of services through citizen-based principles and general revenues. The other three cases organize around social insurance and since the 2000s have relatively similar degrees of unification around a single fund.

Funding differences are also significant among the three countries with social insurance. Even though in all four cases the state financially supports the poor and the self-employed, in Costa Rica and Uruguay such funding role is more generous and also reaches non-salaried workers. Support for low income groups that are above the poverty line is particularly important if real access is going to be secured and fragmentation avoided.

Another significant difference has to do with the rules setting **benefits.** In Costa Rica, the state does not limit the services available, which include expensive treatments for rare diseases and for HIV. In Uruguay, there is no exclusion list but beneficiaries must share the cost of some services. In South Korea, health insurance takes care of a defined package of services and also involves co-payments. Private providers constantly push not to expand such package to incorporate new treatments because it is more profitable for them to sell them out-of-pocket. In Mauritius, all benefits are theoretically covered.

The third difference has to do with **service provision**. In Costa Rica and Mauritius services are delivered by public facilities. Fragmentation is thus low and reflects on more standardized benefits across facilities and on similar protocols to address similar illnesses. At the other end, in South Korea public facilities play a minor (and decreasing) role and social insurance mostly rely not for profit private providers. In 2011, there were only 191 public hospitals compared to 2,873 private ones of different size (OECD, 2014). Fragmentation is high even formally: each provider can deliver services in different ways and shared protocols (overseen by the National Health Insurance, NHI) are weak. In between the two extreme situations of Costa Rica and Mauritius on the one hand, and South Korea on the other, Uruguay combines not-for-profit private providers with public facilities. Under the reformed National Health System, packages are becoming more standardized across providers and fragmentation is tackled by shared protocols of attention.

Finally, there are significant cross national variations regarding the role of the **outside option.** Mauritius set in place Scandinavian-like arrangements but with a large role for private providers from very early on. The outside option is also prominent in South Korea and reflects in two different arrangements. On the one hand, private insurance companies are available, particularly to high-income groups. In 2009, private insurance was responsible for 10.6% of in-patient services and 5.2% of total health spending (Jeong and Shin, 2012). On the other hand, there are still a large number of benefits that remain outside the NHI package.

In Costa Rica and Uruguay a lower out-of-pocket spending reflects a smaller role of the outside option—although it still poses a significant threat to universal outcomes.

The analysis summarized in Table 3.2 demonstrates that what matters is not just how each component operates but how they interact with each other to define the ultimate character of the architecture. Although the differences in this regard have diminished over time, they are still significant:

- South Korea and Uruguay, which historically had an architecture based on insurance funds organized around firms and occupations, still show more fragmentation across all dimensions. For example, in Uruguay, the poor have access to different medical facilities than middle class individuals. In Korea, there are still many procedures that are not included within the NHI and high co-payments also limit the effective access among many people to procedures theoretically available.
- In Mauritius, unification is high in several areas, but the existence of a prominent outside option introduces high degrees of fragmentation in practice.
- Costa Rica is the closest example of a unified state-led system, even if the growth of the private sector has become a significant threat. The country has a unified system of social insurance managed by only one institution and funded by tripartite contributions. There are no co-payments and the state is at the center of organizational arrangements, including service delivery.

Table 3.2
Current policy architectures in health care: Policy instruments by country and dimension

Components	Mauritius	Costa Rica	South Korea	Uruguay
a. Under what conditions can people benefit?	As citizen	As insured (mandatory workers, family or poor)	As insured (mandatory salaried workers, mandatory self-employed, family or poor)	As insured (mandatory workers/occupation-based, family or poor)
b. Who pays and how?	General revenues	Tripartite contributions and social assistance	Bipartite contribution to single fund + co-payment	Tripartite contribution to single fund + co-payment
c. Who and how are benefits defined?	State; in theory all services	State; all services	Tripartite committee including trade unions, employers and doctors and hospital managers reviews NHI policies	State; all services
d. Who provides?	Public facilities for all	Public facilities for all	Mostly not for profit private firms with a minor presence of public providers	Not for profit (middle-income) and public (poor)
e. Management of an outside (market) option?	Outside option is large and generally unregulated	Outside option is growing and unregulated	Large number of benefits outside the NHI package	Small number of unregulated private providers. Also, large number of not-for-profit, regulated providers.

Source: Own elaboration.

We explore now the implications that these differences in policy architectures have in reaching universal outcomes. Since we are particularly interested in the extent to which countries reach different groups of the population along occupational or socioeconomic lines, we evaluate access, generosity and equity for three groups: salaried; the self-employed and the poor.

We break down *access* in three categories (a third = 0; two thirds = 1; everyone = 2). We approach *generosity* by combining the type of services covered (basic, non-basic and full coverage) and the fiscal commitment to it (low, medium and high). In evaluating the services covered we take into consideration effective provision: for example, long waiting lists for specialists create problems, particularly for the poor (who are likely to have less resources to overcome them through discretionary mechanisms). We have three different alternatives: low-low (0); high-low or low-high (0); high-high (2). For *equity* we combine the presence of co-payments and state subsidies (co-payment and no state subsidy = 0; subsidy and co-payments = 1; subsidies without co-payments = 2).

Table 3.3 presents the aggregated coding of countries. Costa Rica scores 17, Uruguay 15, Mauritius 14 and South Korea 12. The coding is primarily based on secondary literature on health care in each of the countries. Even though countries tend to performed similarly across groups, in Uruguay, when measured by equity universal outcomes do not yet reach the poor same as the salaried workers and the self-employed. In South Korea, the very poor—just 3.7% of the population in 2009—were not required co-payments but everyone else did independently of their income level.

Costa Rica receives the highest mark because everyone has access to the same services so that equity is high. Generosity is also high in terms of public spending, but faces problems due to increasing waiting lists for specialists. Although these are theoretically a problem for all income groups, the poor suffer disproportionally because it has fewer social and financial resources to confront them. Despite significant improvements in recent years, South Korea is still the lowest in the ranking because of low public spending and high co-payments that affect equity.

Table 3.3. Index of universal outcomes per country by dimension, category, and total values

Country	Salaried	Score	Self-employed	Score	Poor	Score	Total
Costa Rica							
Access	All	2	All	2	All	2	6
Generosity	High-high	2	High-high	2	Low-high	1	5
Equity	High	2	High	2	High	2	6
Total		6		6		5	**17**
Mauritius							
Access	All	2	All	2	All	2	6
Generosity	High-low	1	High-low	1	Low-low	0	2
Equity	High	2	High	2	High	2	6
Total		5		5		4	**14**
South Korea							
Access	Most	2	Most	2	Most	2	6
Generosity	High-low	1	High-low	1	High-low	1	3
Equity	Low	0	Medium	1	High	2	3
Total		3		4		5	**12**
Uruguay							
Access	All	2	All	2	All	2	6
Generosity	High-high	2	High-high	2	High-low	1	5
Equity	Medium	1	Medium	1	High	2	4
Total		5		5		5	**15**
Source: Own elaboration.							

Coding: *Access:* a few (1/3=0); most (2/3=1); all (=2); *Generosity* combines low, medium and high formal availability of services (only basic; basic and non-basic with restrictive package; basic and non-basic with no restrictions) and low, medium or high spending. When combined results in low-low (=0), low-high or high-low (=1); and high-high (2); Equity: no state subsidy and co-payments (=0); state subsidies and high co-payments (max 50%) (1) and state subsidies without co-payments (=2).

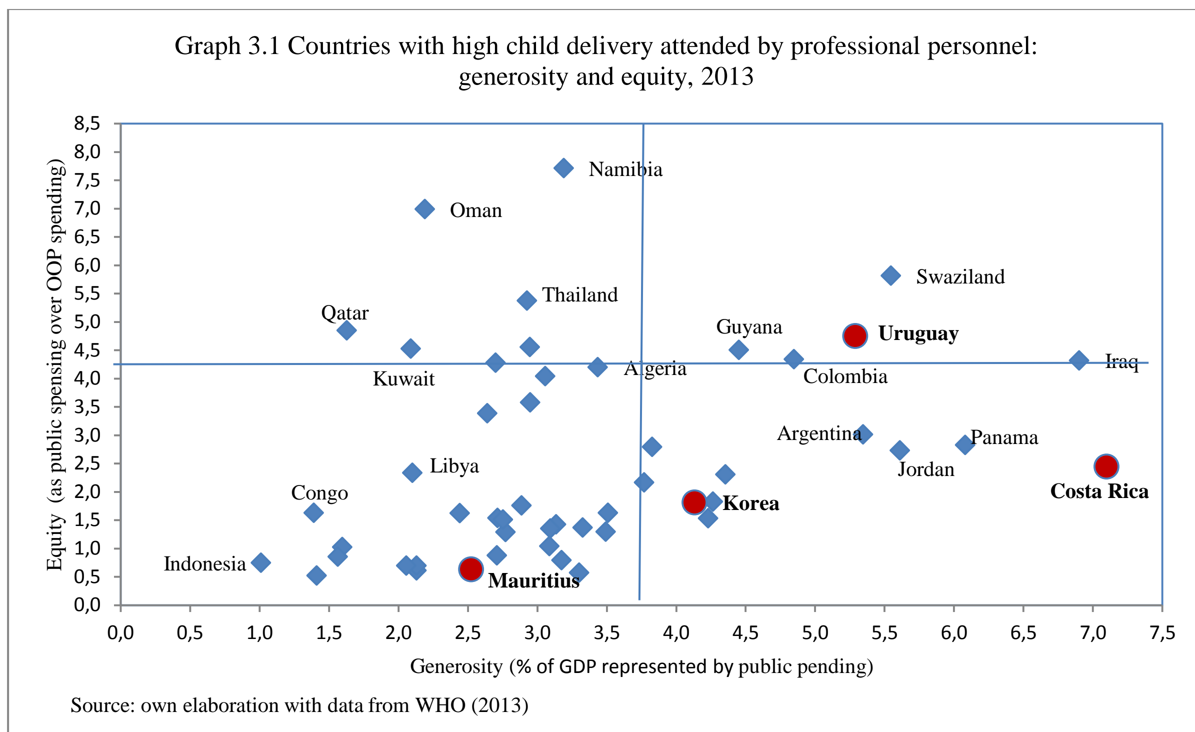
4. The common threat of the outside option

In a recent review of the implementation universal health coverage in the periphery, the World Bank argues that "delivery [in the different cases analyzed] is undertaken through public, private, for-profit, or not-for-profit providers or a mix of them… (probably the majority) rely to some extent on a mix between public and private providers" (2013: 4) and does not see any problem with this pattern. Yet this is a rather technocratic approach that overlooks how the existence of an outside private option can reshape public services. A

prominent private sector, even if efficient in the delivery of services, has a negative impact on universalism via fragmentation in all other four dimensions, both in the short and long run.

By an outside option we are broadly referring to the existence of alternatives that push towards a larger role of markets in allocating resources. Although we usually focus on the existence of private hospitals, outside options can involve many other arrangements. For example, countries may have a liberal practice completely funded by out-of-pocket contributions; a private provider funded by public resources; or the so-called "dual practice" whereby medical professionals have a foot in public and private provision. The common denominator to all these arrangements is that profit becomes the organizing principle behind the allocation of resources. By leading to fragmentation in access (i.e. between those who can and cannot afford to pay); funding (i.e. between sources that reflect rights and those that reflect purchase capacity); benefits (i.e. between more or less profitable treatments); and provision (i.e. between providers than operate under different rules of the game), all the different outside options undermine universalism.

Finding a single way to measure the outside option is not easy, given its variety and its multiple effects on the other dimensions of the architecture. Yet one approximation can be the share of out-of-pocket expenditure in total health expenditure. Figure 1 considers this number as an approximation to equity and compares it with the level of generosity in health spending (measured as public health spending in GDP) for all countries that have high coverage in a very basic service.



Graph 3.1 Countries with high child delivery attended by professional personnel: generosity and equity, 2013

Source: own elaboration with data from WHO (2013)

The problem of the outside option is particularly significant in the case of Mauritius. There the historical presence of private hospitals for the middle and upper middle class has affected the evolution of public health care over time and – via underfunded and understaff facilities - influenced the level of coverage, generosity and equity. Although Costa Rica traditionally managed the outside option better, it has become increasingly important as people demanding public services has grown more rapidly that social investment, as quality has dropped, and as the number of medical professionals each year entering the labor market has rapidly expanded.

In South Korea, high out-of-pocket spending results from the delivery of public services by private providers. Private providers combine their liberal and NHI practices. Despite governmental attempts to come up with alternative ways of reimbursement, the latter is done per treatment which creates incentives to go for more rather than for less. It also creates incentives to combine treatments included under the NHI with newer and costly treatments that are not. Access to the NHI has, in this sense, expanded the market for private practice. This situation has created a spiral of increasing spending in highly sophisticated medical treatment. The outcome is high private spending with low equity. Indeed, in 2011 South Korea had the third highest private spending among the OECD countries, after Chile and Mexico.

Uruguay is the best performer of the four in terms of out-of-pocket expending. Low out-of-pocket expenditure can partly be explained by the irrelevance of the fully private option and a strong state intervention in the not-for-profit mutual aid services - which with the most recent reform has virtually become non-existent as a an outside option. As providers of the NHS, Uruguay also benefits from how non-for-profit mutual aid providers are reimbursed for their services. Each provider receives a per capita per insured person it looks after – unlike South Korea where providers are reimbursed per treatment. Being in charge of people rather than of treatments reduces fragmentation: providers must ensure that all the insured receive the treatment required. Uruguay's increasing and intelligent regulation of the mutual aid associations contrast with the unregulated approach to the dual practice in Costa Rica and Mauritius and Korea's weaker capacity to impose conditions on providers.

5. Pensions as a shadow case

Pensions play a useful role as our shadow case to explore the analytical leverage of the concept of policy architecture. Focusing on a transfer and comparing it to a service like health care allow us to see differences and similarities and acknowledge the diversity of obstacles to universal outcomes.

Table 3.4 summarizes policy architectures for pensions across the four countries analysed. As the only country with a non-contributory pension for everyone funded through general taxes, Mauritius is again the outlier. The payment from non-contributory pensions is equivalent to 20% of the average earnings (Vittas, 2003). This pension is complemented with a unified social insurance pension for salaried workers, which aims to have a replacement rate of 33%. Theoretically, of the four, this Scandinavian-like architecture should be the one most capable of providing universal outcomes. Yet four features in Mauritius lessen the degree to which its architecture favours universal outcomes. First, for the self-employed workers social insurance is voluntarily rather than mandatory —thus limiting access. Second, government updates the value of pensions based on inflation and therefore, the replacement rate of social insurance has been much lower than expected—thus reducing generosity. Third, the outside option has been significant: by the early 2000s Mauritius had more than 1000 private pensions schemes, many of which were corporate based. Finally, the existence of a National Savings Fund made of mandatory, capitalization contributions also reduces the redistributive impact of the architecture and thus its equity. Confirming one of our conclusions in previous sections, Mauritius highlights the importance of considering the architecture as a whole: universal non-

contributory old-aged transfers are extremely important (Barrientos and Lloyd-Sherlock, 2002; Willmore, 2006) but, by themselves, do not guarantee universal outcomes.

Costa Rica, South Korea and Uruguay based their transfers on a combination of social insurance and means-tested, non-contributory pensions. Yet there are significant differences in the interaction between the two, and also in their funding sources. In Costa Rica, most pensions are managed by the same institution (the CCSS).[7] The main source of funding is also the same in both cases: payroll taxes. The main shortcoming in this case is coverage: non-contributory pensions still do not incorporate a majority of the poor, and contributory pensions for the self-employed have expanded rapidly but still leave about a third of workers behind.

In South Korea funds for salaried workers and the self-employed have no interaction with non-contributory pensions. Uruguay has the most fragmented scenario of the four cases, since the general fund (the BPS) coexist with several prominent funds for various occupations; Uruguay's advantage is that it has higher coverage overall than the others. In a sense, the best case scenario would combine the unified architecture found in Costa Rica with Uruguay's high coverage.

[7] Like in the other three countries, Costa Rica has independent funds for different types of public workers, although in this case it is only two, for teachers and the judiciary.

Table 3.4 Current policy architectures in Pensions: Policy instruments by country and dimension				
Contributions	Mauritius	Costa Rica	South Korea	Uruguay
a. Under what conditions can people benefit?	Two pillars: as citizen and as insured salaried workers	Salaried workers, the self-employed and the poor	Salaried workers, the self-employed and the poor	Salaried workers, the self-employed and the poor
b. Who pays and how?	Non-contributory pensions			
	General revenues for basic pension	Payroll and indirect taxes for social assistance	General taxes for non-contributory pension	General taxes for non-contributory pension
	Salaried workers			
	Tripartite contributions (check, maybe bipartite)	Tripartite contributions	Bipartite contribution to the national pension program	Tripartite contribution to occupation-based funds
	Self-employed			
	N/A	State-workers contributions	Workers contributions	State-workers contributions
c. Who and how are benefits defined?	State; defined benefit	State; defined benefit	State; defined benefit	State: defined benefit
d. Who provides?	Public	Public	National Pension program (state managed but without state subsidies)	Public and occupational funds
e. Management of outside option	Existence of an optional private providers as additional tier (funded by workers alone)	Existence of a mandatory private providers as additional tier (for salaried workers; funded with public funds and employer contributions)	Existence of private providers as additional tier	Existence of mandatory private providers as additional tier (for salaried workers; funded by their own contributions)
Source: Own elaboration.				

To conclude, it is useful to highlight a significant difference between architectures in health care and pensions across all countries. Unification is easier to achieve in health care than in pensions. Although with different degrees, in all countries, groups like public servants have succeeded in securing more generous pensions than other workers while they have gradually

been incorporated to common health care services. In addition, while in terms of health care, collectively funded arrangements have made services totally independent from premiums, in pensions, under social insurance, the best case scenario has been one that reflected workers' earnings and contributions. Additionally, the creation of capitalization pillars in the last two decades—influenced by a new international policy model which was stronger and more influential in pensions than in health care—has increased fragmentation in pensions more than in health across the board.

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