Chapter for the book manuscript *More than just democracy: The building of pro-universal social policy in the South*

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Chapter 3

Social policy architectures and universal outputs in four countries

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1. Introduction

In the previous chapter we demonstrated the importance of promoting social policies that deliver universal outputs. Yet this is easier said than done: How can countries in the South build these policies? 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.¹ The 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).

These macro-explanations miss important pieces of the story. On the one hand, they downplay the diverse ways in which policies favourable to universal outputs have been pursued and the significant problems that these “star” cases have faced to reach and sustain universal outputs. On the other hand, even if democracy and political ideology are important preconditions, they cannot explain why pro-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 chapter and the next we focus on the role of policy architectures as an analytic device to study pro-universal policies in the South. We define policy architectures as the combination of policy instruments addressing 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 individual instruments but the interaction between the various instruments set in place to cope with each of the five defining components.

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

¹ 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 pro-universal policies per se. See, for example, Huber and Stephens (2012) or Segura-Ubiergo (2007).
incentives for the subsequent expansion of policies, architectures mediate the interaction between democracy and universalism.

In this chapter we look at countries with robust social policies to explore the diversity of architectures and how they constrain universal outputs. We focus on 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 the social service with the highest impact on inequality and social cohesion. We test the relevance of our primary findings by investigating pensions as a “shadow case” following Pribble’s (2013) methodology as elaborated in our introductory chapter.

Through this analytical comparison, we make three claims. First, we highlight the diversity of policy architectures and question the idea that, by definition, a given architecture will outperform others in terms of enabling universal outcomes. 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; specific ways of organizing social insurance perform as well if not better than the Scandinavian architecture.

Second, we show the importance of studying the interrelation between different components of the policy architecture to explain the obstacles on the way to universalism. Although these obstacles show cross national variations reflecting 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 outputs when everyone enters a single social program in a similar fashion, the state playing a major role in ordering the sector, acting as direct provider and taming the market. We highlight this point by considering Costa Rica’s positive performance.

Third, the outside market option plays a prominent role in limiting universal outputs. Having powerful outside options undermines the likelihood that the other four policy components will 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 is inhibited by the presence of a powerful private sector.
Below we justify our four cases as contemporary successes in social policy provision in the South. We then introduce the concept of policy architecture as a useful analytical tool to explore country differences. In section 4, we compare and contrast policy architectures in health care services across the four countries. Three rely on social insurance with contributions from workers, employers and governments. We highlight Costa Rica’s success at promoting a unified system, speculating about its potential positive effect in terms of universal outputs. 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 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. 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 healthcare and education multiplied by three and by eight real terms, respectively (Trejos, 1991). Between 1950 and 1990, the number of physicians per 1000 people went from 3.1 to 7.8; the number 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 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.

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2 When the policy architectures we discuss here were being set in place, all four countries had a relatively low GDP per capita. In 1960 GDP per capita (in dollars of 2005) was 3,151 in Uruguay, 1,842 in Costa Rica and 1,467 in South Korea (World Development Indicators database). Comparative data for Mauritius is not available until 1976.
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 previous 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 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 South (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 rights-based approach in health, education and social protection (Prible, 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 Fransoni 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).

Since 1990, South Korea has seen dramatic policy change as significant reforms in health, pensions, unemployment benefits and social assistance have been introduced. Public social spending as percentage of GDP more than tripled between 1990 and 2012, from just 2.8% to 9.3%. As discussed in the next chapter, the expansion of benefits in health care is particularly impressive: “compared to Germany’s 127 years, Belgium’s 118, Israel’s 84, Austria’s 79, Luxembourg’s 72, and Japan’s 36 years, South 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 reflect 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 income partly due to a well-known convergence in health indicators—which also have significant upward limits. That South Korea has a GDP per capita 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 influence of cross-national variance in social policy. Infant mortality under 5 years of age is below 1 per thousand in all cases, lower than the world average (35 per thousand) and lower than the average for upper middle income countries (16 per thousand). Performance in life expectancy is also impressive in a comparative perspective and particularly noteworthy in the Costa Rican case.

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Table 3.1 Human Development Indicators, 2012

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


How have these countries managed these achievements, so elusive elsewhere? 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 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 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.

According to authors like Carroll and Carroll (2000), Meisenhelder (1997) and Seekings (2011), the gradual emergence of democratic institutions 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, to backtrack on regressive reform attempts (see Chapter 4).

According to proponents of the democratic explanation, its contribution to expansionary social policy is clearest 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, creating new pressures to expand social spending (Kwon, 2007). As Haggard and Kauffman (2008: 256) show in their studies of South Korea and 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 in the four countries democracy has contributed to the expansion of social policy and social incorporation. However, while Costa Rica, Mauritius, South Korea and Uruguay—and some other democratic societies like Argentina, Chile or the state of Kerala in 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 (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.

4 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).

5 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.
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 a useful analytical devise. Any policy architecture plays two different roles in influencing universal outputs in specific contexts: (a) Statically, different combinations of policy instruments deliver different levels of universalism, when 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 chapter, we focus on the first role, while we discuss dynamic trajectories in Chapter 4.

Policy architectures involve five main components related to who access what, when and how: 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?): 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.

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 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.

c. 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.
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. 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.

We argue that 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.

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 outputs through a policy architecture that (a) reached all citizens; (b) granted generous and high quality benefits funded by general revenues; (c) had the state as the actor both defining and providing benefits; and (d) kept private provisions in check.

Scandinavian-like principles may be ideal, but their implementation in practice in the South has proven extremely complicated. When poorly funded, services for all have ultimately been used by the poor alone, run short of funding and provided limited and low quality services. Expanding taxes to deliver better services—the Scandinavian ultimate solution to secure equity and high quality—has proven particularly difficult across the South.
Can universalism be reached through a different combination of policy instruments than the citizenship-based Scandinavian one? As we will illustrate now with specific examples, universal outputs 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 outputs 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 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. Since the 2000s each case can claim 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 a funding role is more generous and reaches all non-salaried workers. Support for low income groups 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 establishing benefits. In Costa Rica, the state does not limit the services available, which include expensive treatments for rare diseases and HIV. In Uruguay, there is no exclusion list but beneficiaries must share the cost of some services. In South Korea, health insurance only takes care of a defined package of services and involves co-payments. Private providers constantly pressure to limit packages because it is more profitable to sell new treatments as out-of-pocket costs. In Mauritius, all benefits are theoretically covered.
The third difference is found in service provision. On one end of the scale, Costa Rica’s and Mauritius’ services are delivered by public facilities. Fragmentation is low and reflects an increased standardization of benefits across facilities and protocols. At the other end of the scale, South Korean public facilities play a minor and decreasing role; social insurance relies upon not-for-profit private providers. In 2011, there were only 191 South Korean public hospitals compared to 2,873 private hospitals (OECD, 2014). Formal fragmentation is high: providers 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 increasingly standardized across providers and fragmentation is tackled by shared protocols.

Finally, there are significant cross national variations regarding the management of the outside option. Mauritius combined at the onset Scandinavian-like arrangements with a large role for private providers. The outside option is also prominent in South Korea were it plays two different roles. 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, a large number of benefits remain outside the NHI package. In Costa Rica and Uruguay, lower out-of-pocket spending reflects the smaller role of the outside option—although it still poses a significant threat to universal outputs.

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 have diminished over time, they are still significant:

- South Korea and Uruguay historically had policy architecture based on insurance funds organized around firms and occupations (see Chapter 4) and still show more fragmentation across all dimensions. For example, in Uruguay, the poor have access to medical facilities that are different from facilities accessed by middle class individuals. In Korea, there are still many procedures that are not included within the NHI. High co-payments limit effective access to theoretically available procedures for many people.
• 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

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

Source: Own elaboration.

We explore now the implications that these differences in policy architecture have in reaching universal outputs. 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 workers, self-employed, and 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 fiscal commitment (low, medium and high). We evaluate the services covered by taking into consideration effective provision: For example, long waiting lists for specialists create problems, particularly for the poor (who are likely to have fewer resources to overcome barriers using discretionary mechanisms). We have three options: low-low (=0); high-low or low-high (=1); high-high (=2). Equity combines 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, literature that we extensively discuss in the next chapter. Even though countries tend to perform similarly across groups, Uruguay, when measured by equity universal outputs, does not yet reach the poor equally to salaried workers and the self-employed. In South Korea, only 3.7% of the population (in 2009) were considered very poor and were not required to make co-payments whereas everyone else did, independent of income level.

Costa Rica receives the highest mark because everyone has access to the same services. 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 they have 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 affecting equity.
### Table 3.3.
Index of universal outputs per country by dimension, category, and total values

<table>
<thead>
<tr>
<th>Country</th>
<th>Access</th>
<th>Generosity</th>
<th>Equity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Costa Rica</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>All</td>
<td>High-high</td>
<td>High</td>
<td>6</td>
</tr>
<tr>
<td>Generosity</td>
<td>High</td>
<td>Low-high</td>
<td>High</td>
<td>5</td>
</tr>
<tr>
<td>Equity</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>6</td>
</tr>
<tr>
<td><strong>Mauritius</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>All</td>
<td>High-low</td>
<td>Low</td>
<td>2</td>
</tr>
<tr>
<td>Generosity</td>
<td>High</td>
<td>Low-low</td>
<td>High</td>
<td>2</td>
</tr>
<tr>
<td>Equity</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>6</td>
</tr>
<tr>
<td><strong>South Korea</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>Most</td>
<td>High-low</td>
<td>High</td>
<td>3</td>
</tr>
<tr>
<td>Generosity</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>3</td>
</tr>
<tr>
<td>Equity</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>3</td>
</tr>
<tr>
<td><strong>Uruguay</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>All</td>
<td>High-high</td>
<td>High</td>
<td>5</td>
</tr>
<tr>
<td>Generosity</td>
<td>Medium</td>
<td>High-low</td>
<td>High</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Own elaboration.

Coding: Access: a few (1/3=0); most (2/3=1); all (3=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 of universal health coverage in the South, 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 identify problems with this pattern. This is a technocratic approach overlooking how the existence of an outside private option reshapes 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 dimensions in both the short and long term.
Outside option refers broadly to the existence of alternatives driving a larger role for markets in allocating resources. Although often used when focusing on the presence 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. All these arrangements have profit as the organizing principle behind the allocation of resources. Subsequently these arrangements lead 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 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. One approximation we have found to be effective is the share of out-of-pocket expenditure in total health expenditure. Figure 3.1 considers this number as an approximation to equity and compares it to the level of generosity in health spending (measured as public health spending in GDP) for all countries with high coverage in a very basic service.

![Figure 3.1 Countries with high newborn delivery attended by professional personnel: generosity and equity, 2013](source: own elaboration with data from WHO (2013))
The problem of the outside option takes on different shapes in our case studies. It is particularly significant in the case of Mauritius. The historical presence of private hospitals for the middle and upper middle class throughout the country has affected the evolution of public health care over time and – via underfunded and understaffed facilities - influenced the level of coverage, generosity and equity. Costa Rica has traditionally managed the outside option better than the other three countries. Yet it is a growing threat as the demand for public services is growing more rapidly that social investment, quality is dropping, and the number of medical professionals entering the labor market each year is rapidly expanding (see Chapter 7).

In South Korea, high out-of-pocket spending is a result of the delivery of public services by private providers with private providers, who combine their liberal and NHI practices. Despite governmental attempts to come up with alternative ways of reimbursement, the latter is done per treatment, creating incentives to pursue quantity. It also creates incentives to combine treatments included under the NHI with newer and more costly treatments that are not. This situation creates spirals of increased spending on highly sophisticated medical treatment. The outcome is high private spending with low equity. Indeed, as discussed in more detail in the following chapter, in 2011 South Korea had the third highest private spending among the OECD countries, after Chile and Mexico. Uruguay is the best performer on out-of-pocket spending measures when considering our four cases. Low out-of-pocket expenditures are partially explained by the irrelevance of the fully private option and a strong state intervention—introduced with the latest reforms—in the not-for-profit mutual aid services. Uruguay also benefits from how non-for-profit mutual aid providers are reimbursed for their services when providing services for the NHS. Providers receive a per capita per insured person they manage – unlike South Korea where providers are reimbursed per treatment. Being in charge of people rather than treatments reduces fragmentation: providers must ensure that all 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 South Korea’s weaker capacity to impose conditions on providers.
5. Pensions as a shadow case

Pensions play a useful role as a shadow case when exploring the analytical leverage of policy architectures. Comparing transfers to services (e.g. health care) permits a view of differences and similarities while acknowledging the diversity of obstacles to universal outputs.

Table 3.4 summarizes policy architectures for pensions across the four countries analysed. As the only country with a non-contributory pension for all 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, this Scandinavian-like policy architecture should be the one most capable of providing universal outputs in the four countries discussed. Yet four features of the Mauritius case diminish the extent to which its policy architecture favours universal outputs. First, for the self-employed, social insurance is voluntary rather than mandatory, limiting access. Second, the government updates the value of pensions based on inflation (and not average wages) and therefore, the replacement rate of social insurance has been much lower than expected, reducing generosity. Third, the outside option is significant: by the early 2000s, Mauritius had more than 1,000 private pension schemes, many of which were corporate based, reducing equity. Finally, the existence of a National Savings Fund made of mandatory, capitalization contributions also reduces the redistributive impact of the policy architecture and again, equity. Confirming our conclusions in previous sections, Mauritius highlights the importance of considering policy 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 outputs.

Costa Rica, South Korea and Uruguay base 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 (CCSS).6 The main source of funding is also

6 Like in the other three countries, Costa Rica has independent funds for different types of public workers, although in this case it covers only two: teachers and the judiciary.
the same in both cases: payroll taxes. The main shortcoming in this country 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 as the general fund coexists with several prominent funds for various occupations. Uruguay’s advantage is that it has higher coverage overall than do the others. In a sense, the best case scenario would combine the unified architecture found in Costa Rica with Uruguay’s high coverage.
Table 3.4
Current policy architectures in pensions: Policy instruments by country and dimension

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Mauritius</th>
<th>Costa Rica</th>
<th>South Korea</th>
<th>Uruguay</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Under what conditions can people benefit?</td>
<td>Citizens and insured salaried workers</td>
<td>Salaried workers, the self-employed and the poor</td>
<td>Salaried workers, the self-employed and the poor</td>
<td>Salaried workers, the self-employed and the poor</td>
</tr>
<tr>
<td>b. Who pays and how?</td>
<td>Non-contributory pensions</td>
<td>Payroll and indirect taxes for social assistance</td>
<td>General taxes for non-contributory pension</td>
<td>General taxes for non-contributory pension</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried workers</td>
<td>General revenues for basic pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipartite contributions unless there is deficit</td>
<td>Tripartite contributions</td>
<td>Bipartite contribution to the national pension program</td>
<td>Tripartite contribution to occupation-based funds</td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>N/A</td>
<td>State-workers contributions</td>
<td>Workers contributions</td>
<td>State-workers contributions</td>
</tr>
<tr>
<td>c. Who and how are benefits defined?</td>
<td>State; defined benefit</td>
<td>State; defined benefit</td>
<td>State; defined benefit</td>
<td>State: defined benefit</td>
</tr>
<tr>
<td>d. Who provides?</td>
<td>Public</td>
<td>Public</td>
<td>National Pension program (state managed but without state subsidies)</td>
<td>Public and occupational funds</td>
</tr>
<tr>
<td>e. Management of outside option</td>
<td>Existence of optional private providers as additional tier (funded by workers alone)</td>
<td>Existence of mandatory private providers as additional tier (for salaried workers; funded with public funds and employer contributions)</td>
<td>Existence of private providers as additional tier</td>
<td>Existence of mandatory private providers as additional tier (for salaried workers; funded by their own contributions)</td>
</tr>
</tbody>
</table>

Source: Own elaboration.

To conclude, it is useful to highlight a significant difference between policy 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 such as public servants have succeeded in securing more generous pensions than other workers while
gradually gaining incorporation into common health care services. Additionally, for health care, collectively funded arrangements have made services totally independent from premiums; for pensions under social insurance, the best case scenario is one reflecting workers’ earnings and contributions. Additionally, the creation of capitalization pillars in the last two decades—influenced by a new international policy model that is stronger and more influential in pensions than in health care—has increased fragmentation in pensions more than in health care across the board.
References


Chapter for the book manuscript *More than just democracy: The building of pro-universal social policy in the South*

J. Martínez Franzoni and D. Sánchez-Ancochea

**Chapter 4**

The long-term influence of policy architectures

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1. Introduction

Policy architectures do not only explain the degree of universal outputs in the short term (as discussed in the previous chapter), but also influence the trajectory of policies over the long term. If social programs exclusively incorporate high income groups, pressures to reach out to lower-income groups will be weak. If policies depart from the poor, robust transfers will be unlikely and services will not have sufficient quality to attract higher income groups. If provision of services is exclusively private, preventing fragmentation and delivering standardized benefits for the whole society is unlikely.

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. 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. Defining the foundational architecture of old-age transfers in Uruguay is much harder due to the blurred boundaries between public and private sectors since the inception of old-age transfers.

We identify two distinct and dynamic roles of policy architectures. First, policy architectures empower some actors and create a set of (financial and political) incentives influencing the direction of subsequent reforms. Secondly, policy architectures constrain the number of possible reform alternatives that social and state actors can pursue. Our point is not that policy architectures exclusively determine universal outputs – democracy and policymakers are obviously important—but that they make this effort easier or harder as well as more or less gradual across national contexts.

We develop this argument by describing foundational architectures and their evolution over time in health care and pensions in Costa Rica, Mauritius, South Korea and Uruguay. We show that both advances as well as set-backs can take place in democratic contexts. For

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1 We ignore initial attempts that may have been exclusively private such as those driven by religious organizations.
example, Costa Rica and Uruguay had electoral competitions for most of the first two thirds of the 20th century, yet social policies in the former delivered more universal outputs than in the latter. In Mauritius, electoral competition and the presence of left-wing coalitions favored the expansion of health and non-contributory pensions during the second half of the twentieth century. However, the same democratic institutions did little to curb the outside private option.

By comparing the evolution of policy architectures in all four cases, we also question mono-causal explanations regarding the impact of globalization—thus confirming some of Haggard and Kaufman’s (2008) conclusions about the uneven evolution of social policy across the world since the 1980s. During the last three decades, South Korea and Uruguay have introduced changes in their policy architectures placing them closer to universal outputs than ever before. In Uruguay, the 2000-01 crises fed a larger set of reforms that unified the policy architecture.\(^2\) In the late 1990s, South Korea strengthened a policy architecture favorable to universalism paradoxically at a time when it was experiencing heavy pressures from international institutions.

2. Health care

Our comparative analysis of policy architectures in health care demonstrates how steps toward state-led unification have taken place at different moments and at different speeds. In Uruguay and Korea the foundational architecture was highly fragmented due to the prominence of multiple insurance funds (segmentation) and the active role of private actors (marketization). Such fragmentation initially complicated steps towards universalism. Uruguay maintained a highly stratified health care system for almost a century. In South Korea, fragmentation has remained high even in the presence of unification pressures in a democratic context.

Despite these common obstacles, efforts towards unification in Uruguay have had several advantages over South Korea’s. Private providers were not-for-profit organizations with

\(^2\) Even in Costa Rica and Mauritius, where private provision of welfare services has recently expanded, it is hard to see the set-backs as driven primarily by international competition. In fact, in Costa Rica during the last decade, social spending in health and other areas has increased at the same time as fragmentation forces strengthened.
strong incentives to offer affordable services to their members rather than maximizing revenues. Also, the state has always played an important role in the actual provision of services in Uruguay, particularly for the poor. In Korea, both insurers and providers drive fragmentation. Providers are in good financial health, charge per treatment and benefit from low state involvement – for instance in regulating the supply of non-insured services - and from the existence of co-payments.

Since the mid-20th century, Costa Rica and Mauritius have 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 Mauritius, the foundational policy architecture was built on general revenues and services for all. However, the existence of a large and unregulated outside option constrained unification from very early on. The outside option is a recent and growing problem in Costa Rica, which, nevertheless, still maintains a relatively pro-universal system.

2.1. Costa Rica

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 unique characteristics 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); and (3) from the onset, funding was tripartite with contributions from workers, employers and the government.

These characteristics of the initial foundational architecture influenced the subsequent expansion of health services. In 1960, the CCSS bureaucrats argued that the combined pressures of growing service demand and governmental debt jeopardized the financial

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

4 Insurance was initially mandatory for urban workers making up to US$54.0 monthly wages at the 1941 exchange rate.
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. Discussing the budget for 1970 in a meeting of 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).

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. 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. 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 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

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

6 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).
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”. 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 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 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).8

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.

7 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).

8 FODESAF was also partly funded with newly created sale taxes.
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 lead to more radical transformations of the policy architecture (e.g. private administration of payroll taxes and facilities).
Costa Rica: the most successful architecture preceding global pressures

First decades of the 20th century: The poor rely on religious charity and the non-poor on liberal medical practice (and in charity hospitals when in need of inpatient services).

1941: Creation of social insurance with three main characteristics: (a) bottom up incorporation along income lines; (b) unified fund managed by a single institution; and (c) tripartite funding.

1961: Constitutional reform mandates the expansion of coverage to all Costa Ricans.

1970s: Elimination of wage ceiling, unification of hospitals and targeted measures to incorporate the poor to the unified system.

1980s-2000s: Poorly managed reforms weaken services and expand an array of outside private options which have a negative feedback effect on the unified policy architecture.

2.2. Mauritius

We place the foundational architecture of Mauritius in the early 1950s, when newly created democratic institutions still under colonial rule created incentives for the expansion of services and personnel. Immediately prior to this time there were two public hospitals and six Poor Law Hospitals. Also, 39 public dispensaries across the island delivered some basic services by general practitioners for a few hours per day. Yet the number of medical and

9 Each sugar estate also had its own hospitals (there were 40 of them), but they had few doctors and poor infrastructure and, in general, sugar workers and their families preferred to go to the few government facilities available (Parahoo, 1986).
nursing staff was still limited; maternity and child welfare were privately managed; and the government focused almost exclusively on the poor (Titmus and Abel-Smith, 1968[1961]).

During the 1950s, the number of trained nurses and doctors grew and the government opened welfare centers for children and their mothers. In 1959, the Government Medical Service was launched with out-patient services provided by 74 doctors in the hospital and in dispensaries all across the island (Titmus and Abel-Smith, 1968[1961]).

Despite all these improvements, “at the end of the 1950s, health services were in a sorry state. Saturation point in the hospitals had long been surpassed (...). In the ambulatory sector, the situation was equally unsatisfactory” with long waiting lists and an insufficient number of doctors (Dommen and Dommen, 1999: 45). The upper middle class and the wealthy still preferred to rely on private facilities and private spending represented an estimated 40% of the total (Titmus and Abel-Smith, 1968[1961]).

Mauritius’ foundational architecture was thus characterized by (a) a public primary care and hospital system funded through general taxes, (b) a large outside option that serviced the upper middle class and the wealthy and (c) an unregulated dual practice—with doctors working simultaneously in the public and private sectors. These three characteristics influenced subsequent developments and consolidated a formally pro-universal system that in practice was fragmented.

During the 1970s and 80s public health made significant progress from primary to tertiary levels. Massive campaigns succeeded in eradicating malaria (an effort that had begun in the late 1950s), expanding immunization and diverting additional funding to maternal and child services and health education programs (Republic of Mauritius, 1971; Valaydon, 2002). Additionally, the number of community health centers increased significantly and by the 2000s there were 25 area health centers and 81 community centers (Sonoo, 2012). Since the early 1970s, health centers were also responsible for maternal and child welfare as well as family planning. The building of a new hospital was completed in the early 1970s and new beds were added to the system.

Yet quality remained a problem at all levels and the upper middle class and the wealthy were never fully incorporated to the national health system. Parahoo (1986) is particularly critical of the state of care at the end of the 1970s. In his view, “health planners decided to build health centers without seriously considering giving them the important role and function that
is necessary if the health needs of the people are to be met. Lack of planning is also reflected in the fact that no prior assessment of the health needs of the population was made” (p. 204). There were large waiting lists and insufficient services at the local level. The system was increasingly geared towards curative services at the tertiary level: the number of specialist doctors had increased from just four in 1950 to 144 in 1981 with the ratio of non-specialist to specialists decreasing from seven to less than three.

The private sector remained prominent: in 1979 there were six private clinics offering a growing number of services, including laboratory analysis and radiography. They could charge prices freely as there was no adequate state regulation. Private practice was geared towards the wealthy and it was quantitatively more significant for outpatient than for inpatient hospitalization services.\(^\text{10}\) This lack of commitment to the public system by high income groups became a major source of fragmentation: “the rich, often the more educated and more powerful as pressure groups have little interest in advocating better health care in hospitals and dispensaries since they hardly use the services of these institutions” (Parahoo, 1986:238).

Dual medical practice was responsible for significant conflicts of interests: a 1980 report from the opposition Mauritian Militant Movement (MMM) warned that “the same persons who are in a position to determine the level of medical care and efficiency of hospitals and dispensaries also happen to benefit financially if people are forced to rely more and more on private medical services because they are dissatisfied with hospitals and dispensaries” (Parahoo, 1986: 236). Dual practice remained poorly controlled in terms of working hours in public facilities and not regulated at all in terms of professional fees in private services.

Since the 1980s, the public sector has continued to expand and a large proportion of the population relies on it. Still, problems persist and the public-private split has intensified. By the mid-1990s, child immunization coverage remained at 80% (the same as twenty years before), waiting lists in hospitals were significant, and the ratio of nurses to doctors (a good measurement of a country’s commitment to basic, preventive health) had dropped (Dommen

\(^\text{10}\) While the number of private doctors was relatively high, the role of inpatient private medical services was not: in 1979 the private hospitals only had 190 beds compared to 2,840 in the public sector and was responsible for only 5.7% of all child deliveries (Parahoo 1986:p. 233).
and Dommen, 1999). A 1995 study showed broad dissatisfaction with health care, with some patients complaining that public doctors had asked them to visit their private practice (Lingayah, 1995: 369).

By the 2000s, the role of the private sector in health care was high and still growing. In 2001 private expenditure already represented 48% of the sector total and by 2008—the peak year—it had increased to 66%—significantly higher than in Costa Rica, South Korea and Uruguay. In the early 2000s there were 14 private clinics, 20 private medical laboratories and 275 private pharmacies. In 2002 the private sector had only 14% of all beds available in the country (588 out of 4,297) but hired 37% of doctors full time (413 out of 1107) as well as others part time (Ministry of Health 2002).

The WHO (2006) provides additional data on the characteristics and class distribution of private health spending in Mauritius. In the early 2000s, out-of-pocket expenditures represented around 8% of total household expenditure with a similar share for all income groups. 11 In absolute terms more than half of all out-of-pocket expenditure came from the richest 20% of the population. The type of private expenditure varied significantly among income groups. The poorest quintile devoted two thirds of their out-of-pocket expenditure to drugs, twice as much as the 30% among the top quintile. In contrast, 34% of the private spending among people in the top quintile went to impatient services (compared to 21% for the rest of the population), confirming that they account for most of the demand for private hospitals.

The expansion of the private sector, which deepens fragmentation, is likely to continue in the future for at least two reasons. First, the government is committed to turn Mauritius into a medical hub for specialized treatments like in vitro fertilization and hair replacement (Devi, 2008). Health tourism based on private providers is seen as a strategic driver of economic development and its potential impact on the marketization of health care is not part of the public debate.

11 Private insurance was still relatively unimportant: only 5.8% of the whole population had access to private insurance in 2003 (WHO, 2006).
Second, a 2012 reform permits salaried workers to purchase private insurance drawing on their National Savings Fund. With this reform, the state for the first time has created an incentive to join private health insurance. As a result, a large amount of resources will likely be transferred onto the private system, further expanding the outside option. According to a newspaper’s report: “this is a first step towards the privatization of the health services that would help to reduce the heavy burden on the public health system.”

**Mauritius: universal architecture undermined by market-led fragmentation**

First half of 20th century: The poor rely on public facilities while the non-poor rely on private facilities except for inpatient services.

1950s: Foundational architecture is set in place as 74 full time doctors are hired to provide public outpatient and inpatient services. The system is characterized by a growing public sector, a powerful outside option and unregulated dual practice.

1970s: Public spending grows and new facilities are built; yet insufficient investment and waiting lists limit quality; and the upper middle class and the wealthy use private facilities.

1990s and 2000s: There is a significant expansion in out-of-pocket spending.

### 2.3. South Korea

South Korea’s foundational architecture can be traced to 1977, significantly later than in Costa Rica, Mauritius and Uruguay. At that time, the administration of Park Chung-Hee established mandatory firm-level social insurance in companies with more than 500 workers.

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Funding was based on mandatory contributions from workers and employers and involved minimum public participation: the state regulated the sector but neither contributed financially nor provided most services.

Parallel to the contributory system for workers in large firms, the government created a social assistance health care program for the poor (Medicaid). Funded by the central government, it gave benefits to people who met stringent income and wealth conditions. Medicaid classified the poor into two groups: a minority of people who could not join the labor force because they were too young, too old or disabled (type 1) and those capable of working (type 2). Type 1 beneficiaries had access to those medical services included in the national health insurance list free of charge; type 2 beneficiaries were required co-payments of up to 20% of the cost of the service. Both type 1 and type 2 beneficiaries paid in full for the substantial number of services excluded from the list (Kwon, S. 2000).

Gradually, the National Health Insurance (NHI) expanded to all salaried workers through the creation of firm-based insurance societies incorporating increasingly smaller companies. In 1978, government employees and private school teachers joined through their own insurance society; workers in companies with more than 300 joined in 1979; those in companies with more than 100 workers in 1981 and those in companies with more than 16 workers in 1983. This expansion was relatively unproblematic: there was no financial burden for the government; contributions from employers and employees were relatively low; and employees from large companies were not affected by the creation of other, totally independent insurance societies. Meanwhile, private doctors and providers did benefit from higher demand for health care (Kwon, 1995: 79).

From the beginning, the NHI adopted key features that would have a long-term influence on health care arrangements. First, the state aimed to minimize its direct involvement as funder and service provider. As Ringen et al. (2011: 73) puts it, “in authoritarian and democratic periods alike…the state has enabled itself to both claim ownership of social responsiveness and to pass the buck of practical responsibility on to others.” Second, insurance contributions were low and were accompanied by co-payments of up to 60% of the service cost. Moreover, a significant number of procedures—particularly the newest—were excluded from health insurance. Third, insurance societies were primarily intermediaries: they collected premiums and reimbursed providers but did not attempt to shape service supply and demand. Fourth, service provision was primarily in the hands of private hospitals, which in most cases were
owned by one or several physicians (Kwon S., 2002). Finally, some insurance societies were in better financial conditions than others.

After the transition to democracy in 1988, the government created new regional insurance funds for the self-employed. In the following years 134 rural insurance societies and 117 urban insurance societies were organized for farmers and the urban self-employed (Kim and Lee, 2010). Individual contributions were set based on different factors, including income, properties, sex, age and the number of dependents (Kwon, H., 2007). To promote coverage among the self-employed the government was forced to grant them subsidies which accounted for 46% and 34% of the premium for the rural and the urban self-employed, respectively (Ramesh, 2003).

The health care foundational architecture facilitated the incorporation of the self-employed: non-generous benefits made it possible for contributions to be rather low. As a consequence, most lower-middle income farmers and urban non-salaried workers generally managed to pay their premiums. Low generosity in service provision also made the government subsidy manageable. It is telling that during the implementation of the measure, public health expenditure as percentage of GDP increased by less than a half percentage point—despite the millions of new subsidized beneficiaries—going from 1.0% in 1987 to 1.4% four years later (OECD, 2013). At the same time, co-payments remained high and out-of-pocket expenditure per capita in US dollars (in purchasing power parity) actually increased from 118 in 1987 to 199 in 1991.

Despite claims that by 1989 South Korea had achieved universal health care for all (Peabody, Lee and Bickel, 1995), policy outputs were as far from universal as ever: among workers coverage was broad but generosity was low and inequality high. Meanwhile, non-contributory access through Medicaid decreased significantly due to stringent means-testing in the context of high economic growth. The percentage of those receiving benefits decreased from a peak 10.6% of the total population in 1986 to just 2.8% in 1999 (Kwon S., 2000).

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13 This decision followed a presidential veto to the 1988 Congressional bill that would have incorporated the self-employed and all the existing plans into a single, unified system.

14 In 1978 the government had made health insurance compulsory among government employees and private teachers, paying for 20% of their premiums.
Ramesh (2003) shows that in 1999, only 1.6% of the Korean population received free services (type 1), well below the total number of poor (10% of the population).

The Asian Crisis of 1997 destabilized the system significantly: that year funds for private industry, school employees and government entered into deficit, while the funds for the self-employed had only a minor surplus. By 1998, the combined deficit of all funds was 860 billion won, equivalent to 28% of accumulated reserves (Kwon, S. 2000).

The crisis highlighted the structural problems of having a myriad of relatively small funds. The government had three options, all involving modifications in the policy architecture: expanding contributions, increasing government subsidies or unifying the system. The first one was rather unpopular, particularly since employee contributions from industry, government and education employees had already increased in previous years and macro-economic conditions were now poor. Drawing on higher contributions from the self-employed was difficult as most were poor and adequate information on their income was hard to obtain. Increasing government subsidies was limited by fiscal constraints—some of which came from the post-crisis agreement with the IMF—and the traditional small role of the state in social policy.

In 2000 a Congressional bill unified almost 500 insurance funds into a single insurer, the National Health Insurance Corporation (NHIC). The unification of the system modified a key aspect of the organization of social insurance. Pooling contributions had the potential to create progressive redistribution from high-income, mostly-healthy salaried workers to the poor, the self-employed and the sick. Additionally, even though the state’s financial contribution remained low, coordinating and supervising capacities were substantially expanded. As a result, “the fiscal deficit and crisis of the NHI has become more of a national agenda than a set of local issues, as in the previous fragmented health insurance system” (Kwon, S. 2007: 165), making the state the guarantor of last resort in health care.

Yet unification was primarily driven by financial concerns and not by equity objectives (Park, 2011). As critically summarized by Kwon and Holliday (2007)’s the “NHI reform has had

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15 Before the crisis, there was a single insurance society for government and school employees, 142 insurance societies for private salaried workers (60 of which were based on single large companies), 92 for rural self-employed and 135 for urban self-employed (Kwon, S. 2002).
little more than a limited impact on health coverage... Crucially, the merger has not fundamentally changed the benefit package previously offered by multiple insurance societies... The high out-of-pocket payment by patients is very inequitable because it puts a greater burden on the poor and sick. Even after the merger, inequity seems to remain in the payment of insurance contributions because of problems in assessing the income of self-employed workers.”

High co-payments and private provision of health services – both of which seriously affect generosity and equity - remain the main obstacles to universal outputs. Totally eliminating the former has never entered the policy agenda: it would require a significant increase in the government’s financial commitment. Moreover, despite contradictory evidence, co-payments have been considered positive tools for containing costs and securing personal responsibility (Ramesh, 2008) rather than as problems for equity.

Reducing private provision has not been a priority either: in fact, the percentage of beds provided by the private sector increased from 47% in 1980 to 87% in the late 1990s when more than 90% of the doctors were also in the private sector (Ramesh, 2003). The government, however, has sought to tighten regulation as an instrument to contain health care costs. This is most clear in the case of medical prescriptions. Until 2000, prescribing and selling medicines to patients was a significant source of income for doctors. In many clinics, drugs accounted for more than 40% of total revenues (Kwon and Reich, 2005): profits came from charging patients more than the NHI was charging them. Negative consequences involved the excessive consumption of drugs and cost overruns for the national insurance (Kwon, S., 2007).16

In 2000 the government succeeded in separating drug prescription from drug sales, but at a high long-term fiscal and political cost. First, after doctors struck in protest, the government was forced to increase their fees by 44% (Kwon and Reich, 2005). Second, the reduction in pharmaceutical costs was lower than expected because doctors began prescribing costly branded medicines instead of the less expensive generic ones that prevailed before. Also, at least initially, the number of visits to doctors increased: Kwon speculates that physicians

16 In late 1990s, pharmaceutical expenditures represented 31% of all health care costs, compared to an average of 20% in OECD countries (Kwon and Reich, 2005).
recommended “more frequent visits for patients, in order to compensate for their loss of income from drugs, following the pharmaceutical reform” (Kwon, S., 2007:167). Third, and most important for the long term, the reform created significant animosity between doctors and the government, and reduced the chance of adopting more significant reforms.

Indeed, physicians and hospitals succeeded in preventing the government’s attempt to modify how the NHI reimburse their services—demonstrating the negative effect of having a powerful outside option in the chances of progressive reforms. Traditionally, reimbursement was for each service, creating incentives for providers to go for the most expensive procedures. In the late 1990s, for example, 40% of all child deliveries took place through caesarean sections, which had higher profit margins than natural births (Kwon and Reich, 2005). In 1997 a pilot voluntary program began allocating resources for a few procedures, not per services but per diagnosis related groups (DRG) (Kwon, S., 2007). DRG established payments based on the characteristics of each sickness and the past average costs. Although the pilot program reduced medical expenses and increased cost efficiency, physicians managed to block its expansion by going on strike and pressuring hospitals to oppose the measure. As a result, reimbursement continues to be made based on treatment.

Thus, the foundational architecture has been significantly modified in the past two decades, but two of its features (low state funding and prevailing private provision of services) are still limiting improvements in generosity and equity. Reducing co-payments in the future would require either a significant increase in contributions (which many self-employed could not pay and which it is unclear employers would accept); an expansion in direct taxes (which would be tremendously unpopular and would harm the export-led economic model); or more effective cost-containment policies (that private providers are likely to challenge).
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 associations\(^\text{17}\) (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 the capacity of the state to create new services for the non-poor. Instead, the government enacted mechanisms to oversee

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\(^{17}\) These organizations had begun providing health care services in the mid-19\(^{\text{th}}\) 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).
mutual aid associations in 1943 (Filgueira, 1995). 18 Mutual aid societies were required to obtain state permits to operate and their governing bodies had to meet a number of requirements, including the incorporation of medical professionals. At the same time, they benefit from fiscal exceptions that honor the social value of the service they provided.

By the 1940s, Uruguay’s architecture was thus highly segmented. First, the poor were set apart from the non-poor and received different, lower quality services. 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 contributed to the expansion of benefits among the middle class capable of paying monthly fees, but did not create any pressure to standardize the level, quality and equity of services.

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) was created to centralize contributions: each worker had to make 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). 19 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.


19 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 (Arbulo et al., 2012).
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 influence in shaping several components of the policy architecture (e.g. funding, provision). Yet 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. State subsidies benefited the middle class disproportionally and high co-payments forced many people (even some who were members of mutual societies) to rely on the public sector.

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

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20 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).

21 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).
reform (Pribble, 2013)\(^2\), 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 changes possible.

The first role of the policy architecture is clear when considering the financial pressures for reform. 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.

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, contrary to the South Korean case, 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 National Integral de Salud, SNAIS) in 2008 took 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.

\(^2\) 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).
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 makes payments to providers based on a per capita basis, consideration of age and risks of the beneficiaries (therefore increasing equity by pursuing the removal of adverse selection). FONASA pays similar amounts to the mutual societies and the public provider—thus narrowing a traditional 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 or absence 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. This situation creates a problem to strengthen the public provider since each provider is paid in light of how many of the insured have joined. Fewer people joining the public agency 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 less progressive 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.²³

Uruguay: From growing segmentation to gradual unification

1943: The state begins regulating mutual aid societies. A two-tiered system under which the state provides services to the poor is consolidated.

1970/75: Insurance for salaried workers becomes mandatory. Management of payroll contributions are unified but delivery of services stay fragmented. The state becomes a key financial contributor.

1979: The NRF centralizes the funding of all catastrophic illnesses.

1987: With the creation of the ASSE the state reorganizes public provision to emulate not-for-profit private ones.

2008: Creation of a national health system and a national health fund that unified contributions for the public sector and mutual societies. A more effective payment for services based on *per capita* introduced. Mandatory insurance for children and teenagers.

3. Pensions as a shadow case

Like in health care, in pensions the initial foundational architecture and its subsequent trajectory shows significant differences between Costa Rica and Mauritius, on the one hand,

²³ 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.
and South Korea and Uruguay, on the other. Costa Rica and Mauritius began with more unified systems, which expanded in a pro-universal direction over time. The creation of complementary pillars in the last two decades has eroded equality, but has not modified the policy architecture in a radical way.

Uruguay begun with a large number of funds organized around occupations which the state gradually and painfully tried to unify. Like in health care, incentives towards unification came from financial problems caused by the foundational architecture. Pensions have become more pro-universal but historical inequalities remain. South Korea struggled to incorporate the self-employed to old-age pensions since early on. Also, low state involvement and insufficient contributions limited universal outputs, not so much in terms of coverage as in terms of generosity and equity. The recent creation of a non-contributory pension for the lower income population has not reduced segmentation or fully resolved the lack of generosity, particularly among the poor and the self-employed.

3.1. Costa Rica

The inception and expansion of old-age pensions followed a similar logic to that of health care. The 1941 Social Insurance Law mandated the creation of two programs aimed at providing health insurance and pensions. A payroll contribution would fund them both: in the case of health care, resources were largely invested; in the case of pensions, the agency enacted a partial capitalization fund. The newly created pension insurance, like health care, had positive features for the promotion of universal outputs: it first incorporated low income workers to a mostly unified and state-led system.

We say “mostly unified” to point at one major difference between the foundational architecture of health care and pensions. For pensions, a few groups, including workers in the municipality of San Jose and other public employees, succeeded in protecting the occupational plans they already had. So even if 7 out of every 10 salaried workers ended up insured under the single collective fund, segmentation – which was not an issue in health care – was present in old-age transfers.

The policy architecture contributed to expanding the general pension fund in a similar vein as it did in health care, although at a slower pace. For example, the launching of the program was delayed until 1947. In 1963, coverage was almost half of that in health care (16% and 31% of the occupied population, respectively). The wage ceiling was lower in pensions than
in health care during the 1950s and 60s (which meant that a higher proportion of middle and higher income groups were not obliged to contribute) and was removed later as well. These differences in timing are not surprising: for a still young population, the urgency of improving health care was more pressing than the need for old-age security.

During the 1970s a large proportion of the poor population was granted old-age pensions through a similar funding mechanism as health care. FODESAF devoted considerable resources to a means-tested non-contributory pension (Régimen No Contributivo de Pensions, RNC). The RNC was influenced by the existing policy architecture in at least three ways. First, the new pension was promoted by the CCSS as a way to complement its own functions and reach a population unable to pay their premiums. Second, the new non-contributory pension was partly funded through payroll taxes, which were politically easier to expand than direct taxes. This established a rather unusual mechanism of cross-subsidy between salaried workers and the poor, which is not found in the other three countries we discuss. Third, the new regime was administered by the CCSS and seen as part of the unified pension system.

By the mid-1980s, a majority of Costa Ricans had access to a pension granted by the CCSS and funded primarily through payroll taxes. Yet there were still two significant shortcomings: the incorporation of the self-employed to the system was voluntary and the number and level of non-contributory pensions was low. At the same time, like the rest of countries in the South, Costa Rica faced international pressures to move its pension system to a capitalization one managed by private actors. It also had to deal with the growing political influence of private financial institutions, which the process of liberalization, beginning in 1984, had strengthened (Martínez Franzoni and Sánchez-Ancochea, 2013).

Electoral results and power struggles within and outside state institutions partly explain Costa Rica’s response to these challenges (see Chapter 7). Yet the policy architecture in pensions was also important by determining which changes were prioritized and limiting the type of reforms that were feasible.

The 2000 Workers’ Protection Law (WPL) created new instruments to improve the collection of contributions and made insurance mandatory for the self-employed (Martínez Franzoni and Mesa Lago, 2003). Driven by international ideas on the need to reorganize existing pensions under a multi-pillar system, non-contributory pensions were also strengthened in terms of generosity: its value was set at no less than half of the lowest contributory pension.
In 2005, replacement rates were made progressive (the higher the income, the lower the rate) and gender equity enhanced through the creation of a reduced pension for people with a shorter labor history. The 2005 reform aimed to expand social insurance revenues and increase incentives for the self-employed to make contributions: not only were these contributions made mandatory but benefits for people with shorter labor histories created additional incentive to pay.

The architecture also played a role in limiting the extent of market-friendly reforms. In 2000, following pressures from the financial sector and international organizations, the WPL made individual savings mandatory for all salaried workers and turned them into the second pillar to the collective fund run by the CCSS. This second pillar drew on a 4.5% payroll tax reallocated from contributions already in place from employers and salaried workers. Benefits complemented replacement rates for salaried workers, yet not for the self-employed (see Chapter 7).

This reform had negative effects upon universal outputs, but it did not go very far when compared to other Latin American countries for at least two reasons related to the pre-existing policy architecture. First, there was no questioning of the tripartite contributions from the state, employers and workers as the funding source of old-age pensions. In fact, the resources for the individual accounts were drawn from fees already in place, including some made by employers. Second, the role of the social insurance agency remained significant: contrary to other countries like Chile, the CCSS was allowed to run individual funds (in competition with the private sector) and the reform was thus sold to the public as one that reinforced the state’s prominent role.
Costa Rica: Unified social insurance as a road towards universal outputs in old-age pensions

1941-1947: Creation of social insurance and implementation of old-age pensions.

1975: Creation of the non-contributory pension.

2000: Legally binding increase in the value of the non-contributory pension; insurance for the self-employed made mandatory; and individual capitalization savings made compulsory for salaried workers.

3.2. Mauritius

Mauritius’ foundational architecture in pensions dates back to 1950 with the creation of a non-contributory universal pension (Seekings, 2007 and 2011). This pension remains a central component of the overall architecture and partly shaped all following measures.24

The 1950 pension provided a maximum monthly income of 15 rupees for people 65 years of age or older. The pension was initially mean-tested and granted to people whose income was under 15 rupees. Responding to social opposition to this low level, the government decided to expand the cut-off point to 30 rupees in December 1950 (Willmore, 2006). As a result of this change, four fifths of the Mauritian population started benefiting from the new program.

For the following 26 years policy concerning old-age primarily revolved around expanding non-contributory pensions to the whole population. Three steps were particularly significant (Willmore, 2003; 2006):

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24 Prior to 1950 a non-contributory pension system for public servants was already in place. It was founded in 1859 for high ranking officials and extended in 1905 to all other public employees. Some large companies had contributory private pension funds, which reached a small percentage of the total working population.
• In 1953, the qualifying age for women was reduced from 65 to 60 years, the maximum pension increased to Rs 20 per month and the income ceiling that made people eligible to receive pensions increased to Rs 35.

• In 1958, pensions became universal partly as a way to reduce administrative costs. Tax arrangements ensured that the measure had progressive effects: pensions were at that time considered taxable income and through income taxes the wealthier people return to the state much of the benefit (Willmore, 2003).

• In 1965, the minimum age for men to receive pensions was also lowered to 60 years of age. To compensate for the increasing costs associate with a larger number of eligible people, a mild-form of targeting affecting just 5% of all beneficiaries was introduced.

In 1976 the government created a contributory pension for salaried workers, the National Pension Fund (NPF) to complement non-contributory pensions. The new contributory pension was based on a unified system that reached all salaried workers regardless of occupations (contrary to the case of Uruguay) and firm size (contrary to the case of South Korea). Payments were based on a “notional defined contribution”: with the 3% contribution from workers and 6% contribution from employers, beneficiaries acquired points, which were then used to calculate their pension.25 The Ministry of Social Security and National Solidarity administered the NPF and the Ministry of Finance controlled the level of contributions and benefits and the type of investments made (World Bank, 2004).

Like in Scandinavian countries (Korpi and Palme, 1998), the new pension was clearly regarded as a complement to the non-contributory transfer—thus expanding more than modifying the previous architecture. The value of the points accumulated by a person over 40 working years was expected to equal a replacement rate of about one third of his or her average lifetime earnings (World Bank 2004). The reform did not target the self-employed, which could voluntarily join the system but would not receive the state subsidy that in other countries – like Costa Rica – makes up for the absence of employers’ contributions.

Simultaneously to the creation of a contributory pension, the government strengthened the non-contributory benefit, now renamed as the basic retirement pension (BRP). From 1976

25 There was a ceiling in the contribution that in 2000 was a monthly salary of 5,535 rupees (US$220) (Willmore, 2003).
onwards, the real value of the benefit expanded rapidly, particularly for people 70 years of age or more. Aimed to be equal to around 20% of average income (World Bank, 2004), by 2004 the average pension was 2.7 times higher than in 1978 and it also represented a higher percentage of GDP per capita (Willmore, 2006).

By the late 1980s, Mauritius’ policy architecture in pensions included non-contributory pensions for all, complemented by contributory pensions for salaried workers. Unfortunately, this complementary pillar was based on low contributions, did not benefit from state subsidies and failed to deliver the expected replacement rates.

Coping with the fragmenting impact of the contributory regime would have required public subsidies and a significant increase in payroll contributions. Rather than following this avenue, the government embraced reforms influenced by the international environment that further increase rather than lower such fragmentation. In 1994 the National Savings Fund (NSF) was created with a 2.5% contribution from (private and public) employers to a defined contribution scheme based on individual capitalization accounts. This system, which was inspired on that of Singapore and other Asian countries, has eroded solidarity since it only benefits formal employers and links contributions and benefits directly.

The outside option has also become increasingly important, partly as a response to the public system’s failure to deliver the expected replacement rates. The number of private pension plans promoted by firms and trade unions or opened by individuals on their own behalf has increased: according to the OECD (2013: 7), “the Mauritian environment has also seen considerable growth of multi-employer or “umbrella” funds… Most of the large trade unions have established national defined contribution schemes and have negotiated an option for their members to belong to such funds, as opposed to membership of an employer-sponsored fund. [Personal] pension plans have gained in importance in recent years.”

At the same time, the political influence of the foundational architecture is evident in the politics of non-contributory pensions, which have remained popular. In 2004, as a response to recommendations from the World Bank, the government imposed limited targeting in the BRP. Months later, the governing coalition lost the general elections party as a result of this unpopular decision, which the new government quickly reversed.
3.3. South Korea

South Korea’s foundational architecture in pensions has its origins in 1986 with the creation of the National Pension System (NPS) right before the transition from the authoritarian regime to democracy.\(^{26}\) The NPS set mandatory insurance for employees in firms with 10 workers or more. By 1990 the NPS reached 16% of the working population, mostly relatively well-off industrial workers. Generosity was theoretically high: only 20 years of contributions were supposed to deliver a 70% replacement rate (Kim and Choi, 2013). However, low contributions and relaxed withdrawal rules lowered replacement rates considerably.

Once the foundational architecture was in place the expansion after democratization occurred in a similar vein to that of health insurance: in 1992 contributions became mandatory for firms with more than 5 employees and in 1995 the NPS reached farmers, fishermen and the self-employed in rural areas. Such expansion did not confront major obstacles since it increased the size of the pension fund (thus expanding growth-enhancing savings) without costing much to companies and workers (since contributions were low) or to the state (which did not provide any subsidies) (Kwon, 1995).

\(^{26}\) Like the other three countries, South Korea created special pension funds for some groups prior to that date: in 1960 the Government Employees Pension Scheme was introduced covering initially 237,000 people. The military personnel were initially included in this scheme but three years later created its own fund. In 1973, the government introduced the Private School Teachers Pension Scheme (Moon, 2008).
Yet by the mid-1990s the limits of the existing policy architecture were evident. The combination of low contributions, no state-subsidy and high replacement rates challenged the financial sustainability of the system. In 1995, the public think tank Korea Development Institute published a report arguing that the national pension funds would be depleted by 2033 (Choi, 2008). Also, the lack of state subsidies and a weak system of reporting resulted in incomplete coverage for the self-employed—despite mandatory coverage.

The 1997 East Asian financial crisis further aggravated the problems, placing pensions at the center of the policy agenda. At that point, all components of the architecture were theoretically set on the table. Proposals for incremental parametric changes competed with a radical transformation of the system designed by the World Bank, which included a sharp reduction of benefits. The World Bank proposed splitting current pensions into two components: the basic pension (that would remain a collective fund) and the earnings-related pension, which would become an individual account managed by competing private actors.

Highlighting the way architectures limit decision-making, the reform implemented was parametric and consistent with the foundational architecture. Replacement rates were slightly reduced (from 70% to 60%) and pensions were expanded to the urban self-employed and to workers in small firms. In addition, payroll contributions were increased to 9% and the number of years required for full benefits increased from 20 to 40.

State involvement remained low and most of the self-employed were forced to pay premiums equivalent to the combined contribution paid by employers and employees.27 Thus, the reform was hardly “a “direct route to reach greater national integrity and social solidarity” as authors like Hwang (2007:10) argue, and actually consolidated previous shortcomings of low generosity and limited equity.

Expansion towards the poor took place along a similar vein: they were included through a specific set of arrangements granting low generosity and entailing low equity. Two more recent reforms creating non-contributory benefits funded through general taxation represent larger departures from the foundational architecture. In 1999, the National Basic Living

27 Only farmers and fishermen received a subsidy, which was one third of their contribution before 2007 and increased to half of their contribution after that year.
Standard Security Act created a means-tested, narrowly targeted social assistance transfer for people of all ages (hereafter the NBLS). Since more than one fourth of its recipients have been senior households, the NBLS in practice became the “zero-pillar” of old age pensions (Moon, 2008). This new transfer expanded the role of the state but low access limits its impact on universal outputs. Indeed the actual number of recipients is less than 10% of senior households age 65 and above. For a single person, benefits correspond to a fourth of the official poverty line.

In 2007, a new non-contributory means-tested measure, the Basic Old Age Pension Scheme was introduced. Unlike the narrow targeting of the NBLS, this pension has benefited the poorest 70 percent of people 65 years of age or more. It is defined as compensation for people’s dedication to national development and child rearing. The pension entails a monthly fixed amount equal to 5% of the value of the national pension (expected to reach 10% in future years). With its introduction, social insurance is complemented by a tax-based benefit that in December 2011 reached over 3.8 million beneficiaries (Kim, 2013).

Yet the impact of these two policies on Korea’s policy architecture and its contribution to universal outputs should not be exaggerated. The combination of means-testing and small income replacement spreads transfers thinly over a large segment of the older population while doing little to reduce poverty among the elderly.28 The new programs have not entailed an expansion of insurance among the self-employed. Coverage is now particularly low at small firms, which tend to have a higher proportion of non-regular workers. Indeed, in companies with 100 workers or more, the lack of insurance is very small – under 4%—compared to more than half of all employees in firms with less than 10 workers (OECD, 2013). Also, some of the workers in large firms benefit from firm-based private pension plans and high income groups have significant outside private options (OECD, 2009).

28 Relative poverty is much higher among the elderly than the rest of the population. The proportion of people between 66 to 75 years of age living in poverty is nearly three times higher than the 15% rate for the entire population (in contrast to the OECD as a whole, where the proportion of the population and the elderly living in poverty is about the same).
3.4. Uruguay

A gradual and cumbersome process of state involvement in a myriad of old-age funds makes the identification of the foundational architecture in Uruguay’s old-age pensions challenging.²⁹ We locate it in 1919 when both a state-driven means-tested, non-contributory pension and the Public Utilities Pension Fund—partly funded through taxes—were created. The tax-funded, non-contributory pension was targeted to the elderly poor 60 years of age or more. The Public Utilities Pension Fund covered railway, telegraph, streetcar, telephone and gas-company workers (Mesa-Lago, 1978). This fund joined other occupation-based private pensions, which had been first created in the late 19th century with contributions from employers and employees.

Regardless of its exact date of inception, three were the main characteristics of the foundational architecture in Uruguay: (a) different funds with diverse benefits; (b) tripartite

²⁹ By focusing on different components of the pensions, the secondary literature is also unclear in this matter.
contributions, with the state acting often as guarantor\textsuperscript{30}; and (c) a non-contributory pension for the deserving poor.

During the following fifty years, the policy architecture remained relatively stable but pension funds grew rapidly. Expansion was particularly fast during the period 1920-40 resulting in the coverage of “the mass of blue- and white-collar workers in the industry, commerce, and various trades and services” (Mesa Lago, 1978). Such expansion deepened occupational segmentation in contributions and benefits.

During the 1960s, the limits of a fragmented architecture became evident: funds started to run deficits and required higher state subsidies, partly as a result of excessive benefits and unsound investments (García Repetto, 2011). In response to these problems, insurance became mandatory and a newly created tripartite agency, the BPS (to which we already referred when discussing health care) attempted to unify all funds in 1967. Yet the very initial fragmentation inhibited unification: the BPS managed to group – yet not to merge - several funds (industry and commerce, domestic service and most of the public sector) but many others (including military, private banks, university professionals, lawyers) opted out. Overall, “no progress appears to have been made in centralizing the collection and distribution of social security, [and] in establishing uniform and rational standards for the various benefits” (Mesa Lago, 1978: 83).

The state’s struggle to unify and rationalize the system continued during the 1970s under an authoritarian regime. The authoritarian military government sought to deepen centralization to secure pensions’ financial stability while reducing the public deficit (Filgueira, 1995). The highly autonomous BPS was replaced by the General Direction for Social Security (Dirección General de Seguridad Social, DGSS) under the rule of the Ministry of Labor and Social Security. The DGSS sought to consolidate not only old-age funds, but also a myriad of other programs like health care, child and maternity care, and family allowances (Mesa-Lago, 1985). The GDSS was responsible for ordering and managing all benefits and coordinating all the para-state retirement funds (Castiglioni, 2000). Again, this attempt at integrating

\textsuperscript{30} García Repetto (2011:5) explains heterogeneous state involvement across funds. For example, the Industry and Trade Fund was formally a collective capitalization system but in practice became an “intergenerational pay-as-you-go models with high dependence from the state”. On the other hand, in the Banking Fund, the state had a managerial role but never acted as a guarantor of the fund.
different programs faced significant constraints: right after the democratic elections of 1984, the funds for notaries, bank workers and university professionals recuperated their managerial independence.

By the mid-1980s, Uruguay had a more unified system than in the 1920s, but there were still independent funds with more generous benefits than others. Also, the non-contributory regime granted very small transfers. Democratization unleashed cumulated demands regarding the generosity of transfers. A 1989 national referendum guaranteed the real value of old-age pensions by linking its rate of growth to that of wages among public workers. A 1990 Law stating that no pension could be under the minimum wage (Papadópulos, 1992) helped to improve generosity among those at the bottom. During the 2000s, non-contributory pensions continued to grow and became less discretionary. A full transfer is set at US$ 360 if the beneficiary lives with family members and a larger one if living alone. Depending on the person’s income, benefits can be full or partial—in which case the subsidy entails the amount needed to reach the US$ 360 cutoff point (Papadópulos, 2013). The measure has helped to decrease the incidence of poverty among people 65 years of age or more.

In 2007-08, other reforms created more options to receive a pension, which had positive consequences for equity (e.g., creation of a pension for people with the required age but insufficient years of contribution). In addition, women were granted a year of contributions for each child born alive which sought to acknowledge income gaps and “double shift” of unpaid work at home.31

All these measures have increased coverage and expanded pensions at the bottom. To-date contributions to old-age pensions reach among the highest coverage in Latin America (about 80% of the economically active population), next to Brazil, Argentina and Bolivia and the system has become more equity-enhancing. Nevertheless, the powerful role of the foundational architecture and the difficulties in overcoming fragmentation are still evident in Uruguay. The country still has independent funds which provide particularly generous

31 A subsequent reform established that replacement rates are now estimated based on the last ten working years (and not the last three) or the best 20 wages during the worker’s historical life (Papadópulos, 2013). This measure prevents workers, particularly in the formal sector, from over-declaring wages at the very end of their employment life as they could do before. It also improves reference wages among the unskilled and more vulnerable workers (such as paid domestic workers) whose wages tend to stagnate after a certain age.
benefits to specific groups. Although the state does not make a direct financial contribution to them, it is provides a *de facto* guarantee. Second, benefits also remain unequal because of the uneven amount of contributions workers are capable of making before they reach 65 years of age (Forteza et al., 2009). The expansion of the number of years required to receive a pension to 35 is also likely to reduce the proportion of workers who will meet this requirement, accentuated among private, low income and female workers (Buchelli et al, 2006).32

The introduction of an individual savings account in 1995 was consistent with historical fragmentation. Following internationally dominant paradigms and responding to funding problems, the government created individual accounts run by the Pension Savings Funds’ Administrators (*Administradoras de Fondos de Ahorro Provisional*, AFAPs). The reform deepened fragmentation for at least two reasons. First, it eliminated all redistribution between individuals, since each person contributes according to his or her wage and benefits match contributions. This means that inequalities in the labor market – such as income gaps between women and men – are fully reflected in old-age transfers. Second, it has opened the door to the private sector, which will likely become a growing actor in the pension system and will push for further marketization.

32 Data precedes the formalization of labor relations that has taken place since 2005. Still, it is unlikely that such formalization will eliminate the problem.
4. Conclusion

Policy architectures 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 the benefits of state social policy and creating different incentives for outside options, they either facilitate or hamper pro-universal reforms. By creating different types of state stakeholders, they create more or less pressures for this kind of 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

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**Uruguay: the long and painstaking task of reducing fragmentation in old-age pensions**

1919: Creation of the first non-contributory pension and a major fund for public companies.

1919-1967: Expansion of an architecture based on segmented mostly tripartite funds, and a reduced non-contributory, targeted pension.


1980s-2013: Introduction of generally pro-universal parametric reforms but also of a capitalization pillar could further fragment the system.
built from scratch like those addressing care, a matter we address in the last chapter of this book.

Mauritius was a sound candidate to have the most pro-universal architecture both in health care and pensions: it created a centralized health care system and a non-contributory pension for all funded with general taxation. However, the existence of a powerful outside option in health, the lack of generosity of the non-contributory pension and the narrowness of the complementary contributory pension limited the positive effects. The case makes it clear that citizen-based architectures are not per se always better for universalism than social insurance ones.

In fact, among the four countries we examine, the Costa Rican architecture stands out as the most friendly to promote pro-universal changes over time. The creation of state-led unified social insurance from early on was better at dealing with tensions between fragmentation and unification than in the other three countries. Costa Rica’s success is particularly striking when compared to South Korea. There, the lack of state involvement in service provision and governmental reluctance to increase public spending were initial features of the architecture that still harm the delivery of universal outputs over half a century later.

Costa Rica is relevant for another important reason: it has suffered growing market-led fragmentation during the last two decades at the time when, paradoxically, South Korea and Uruguay made progress towards unification. Before we try to explain this paradox, we must first explain the determinants of Costa Rica’s uniquely successful foundational architecture. How did Costa Rica create it? How did it evolved over time? How was it able to secure state-led unification—which requires significant state capacity—starting with low income levels? Can electoral competition and ideology by itself explain it? In the following three chapters, we tackle this question and draw lessons for other countries. We show that democracy was a contributing factor, but not a driver of the architecture. Instead, we focus on the interaction between state actors and international ideas in shaping the initial architecture in the 1940s and its development in the 1970s. We also explain the state’s growing incapacity to avoid fragmentation by considering the interplay between state and social experts and changing international ideas since the 1980s.
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