



Achieving universalism in developing countries

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ABSTRACT

Expanding people's capabilities requires health care, education and a sufficient income throughout their lives. But how can policies be designed to ensure social rights and truly enhance capabilities? What should be the role of states and what of markets? Should services and transfers be for everyone or focus exclusively on the poor? This paper provides answers to these questions. We argue that to be effective and successful, social policies should be universal, providing the whole population with similar, generous transfers and services. In this paper, we distinguish between the desired *policy* outputs (coverage, generosity and equity of benefits) and the specific ways to secure them. We organize our argument in five sections. Section 2 fleshes out our framework, which argues for a clear distinction between policy outputs and instruments. Section 3 further develops our definition of universalism, highlighting potential trade-offs between the various dimensions it involves. Section 4 defines the concept of policy architecture and its influence on long-term trajectories. Recognizing that universal outputs will not be secured overnight, Section 5 explores the impact of different trajectories on universalism in the long run, distinguishing between a bottom-up strategy that starts from the poor or other alternatives that involve the non-poor from the onset. Section 6 reflects on the opportunities and constraints that the participation of the private sector creates for universal benefits, calling for its effective regulation. The paper finishes with some analytical conclusions and policy recommendations, which consider the role of politics and institutions and suggest changes at the global level.

Introduction

Expanding people's capabilities requires health care, education and a sufficient income throughout their lives. Ensuring these capabilities can also strengthen the social fabric by creating social ties among members of any given community. Yet how should related policies be designed to ensure social rights and truly enhance capabilities? What should be the role of states and what of markets? Should services and transfers be for everyone or focus exclusively on the poor?

This paper seeks to provide answers to these questions. We argue that to be effective and successful, social policies should be universal, providing the whole population with similar, generous transfers and services. This will demand active state intervention in funding, provision and regulation. Universalism is likely to result in more resources devoted to social needs (Korpi and Palme 1998), avoid the stigmatization characteristic of targeted approaches, increase socioeconomic security and often contribute to more vibrant economies (Mkandawire 2006).

Yet delivering universal social policies is easier said than done. Insufficient resources, prevailing informal economies, high inequality, concentration of power and weak institutions have historically been insurmountable obstacles for most countries in the global South. How can policy makers design credible ways to overcome them?

One recent response has been to propose basic benefits for all as a matter of rights, focusing initially on the poor. The social protection floor approach to public policy aims at securing a minimum level of health care, pensions and other social rights for everyone. Its accent is on a basic guarantee, allowing public social security and markets to provide top-up services for those who can afford it.

This paper recognizes the strengths of this new approach. By providing services as a matter of right, it can shorten social distances, reduce stigma and encourage political engagement. By expanding the amount of resources available, it highlights the importance of social policy. This proposal may be particularly attractive to low-income countries that face significant budgetary constraints and depend on aid support.

Yet the emphasis on *basic* benefits, the de facto role given to markets in the provision of 'non-basic' benefits, and the lack of awareness of politics limit the positive impact of social protection floors. Vaccinating people but failing to treat them against cancer or granting people pensions below the poverty line will not expand capabilities sufficiently. Providing unequal benefits for different citizens may not create the cross-class coalitions required to support further expansions of social programmes. At the end, there is a high risk that a large proportion of people across the South end

up with poor public benefits, while the rest of the population relies on private providers that are too expensive and poorly regulated.

We take a step back and distinguish between what we want to achieve and how we seek to achieve it. To do so, we distinguish between the desired policy outputs (coverage, generosity and equity of benefits) and the specific ways to secure them.¹ To study the latter, we introduce the concept of a policy architecture: the combination of instruments that define which benefits are being offered, to whom and how.

Choosing the desirable/feasible policy architecture—selecting between one that initially focuses on the poor versus one that departs from other groups of the population as well—is both a technical and a political decision. When designing new architectures or reforming existing ones, policy makers must consider the incentives and constraints created in the long run. They should also be aware of the interactions between public and private arrangements and, more specifically, of how the latter shapes the former.

The paper does not offer a one-size-fits-all recipe, but a framework to think about universalism in specific contexts. Depending on pre-existing social programmes, the quality of state institutions, the amount of resources available and the characteristic of the social structure, policy makers may opt for one policy architecture or another. In doing so, they must be aware that universal outputs can be secured through a combination of policy instruments; that creating opportunities for cross-class coalitions is important (therefore, starting from the poor has significant risks); and that thinking about long-term trajectories is also important. Our discussion focuses on class and gender cleavages as a shared challenge for policy across the South, but is hopefully also useful in societies where ethnic divisions are particularly prevalent.

We organize our argument in five sections. The second fleshes out our framework, which argues for a clear distinction between policy outputs and instruments. The third section further develops our definition of universalism, highlighting potential trade-offs among the various dimensions it involves. The fourth section defines the concept of policy architecture and its influence on long-term trajectories. Recognizing that universal outputs will not be secured overnight, the fifth section explores the impact of different trajectories on universalism in the long run, distinguishing between a bottom-up strategy that starts from the poor or other alternatives that involve the non-poor from

¹ In this paper, we do not consider policy outcomes such as the dimensions of human development. Life expectancy and educational results will likely increase in countries that promote universalism, but the specific outcomes will also depend on several social, political and economic factors such as mothers' education, household structure or availability of sewage and basic infrastructure. We cannot assume that all of these factors are mechanically present.

the onset. The sixth section reflects on the opportunities and constraints that the participation of the private sector creates for universal benefits, calling for its effective regulation. The paper finishes with some analytical conclusions and policy recommendations, which consider the role of politics and institutions, and suggest changes at the global level.

A framework to promote universalism: policy outputs, tools and trajectories

There is a growing consensus that universal policies can contribute to the expansion of people’s capabilities both directly and indirectly. If people are to live the kind of lives they value, social rights must be guaranteed independently of people’s resources and assets. But how can universalism in social policy be fostered? In this paper, we offer a novel framework to think about this challenge. In academic as well as policy literature in the North, the term universal has referred to programmes funded through general revenues that provide benefits for everyone on the basis of citizenship. For example, primary education is universal when it covers all children of a certain age free of charge; universal health care provides health services to everyone using general public revenues.

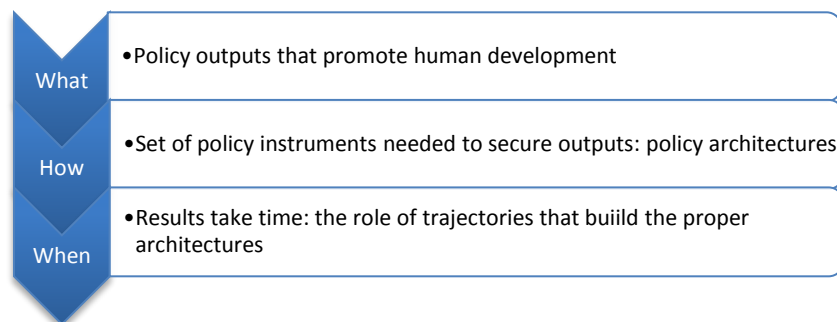
Unfortunately, this definition conflates policy instruments (i.e., means) and outputs (i.e., policy goals)—something that is particularly inappropriate in poor and unequal societies (Fischer 2012). Surely universalism can be reached with instruments other than general taxes, including even out-of-pocket contributions among very wealthy individuals. In fact, if the only road to offering a truly generous set of benefits for all is to rely on generous programmes funded through general taxes, universalism in the South will be beyond reach. As Jennifer Pribble (2013) argues for the Latin American case, “the consolidation of such a welfare state is highly unlikely in the short-to medium run” (p. 8). There may simply be too many obstacles to secure tax-funded, citizenship-based, high-quality programmes in health care, pensions or education in most countries in the South. Yet it is pressing to look for ways to secure similar objectives through a diversity of instruments.²

This is why we propose to separate the policy outputs that governments and other agencies want to achieve from the instruments suitable to achieve them (see Figure 1). The main point is that there may be many different ways to secure the same benefits for a majority of the population using a set of

² Outputs refer to immediate results from policies implemented. In this way, we can distinguish them from ultimate *outcomes*, which result from policies but also from other factors. For example, cuts in infant mortality are a result of better health-care policy but also of mothers’ education and access to clean water.

different policy instruments (social security, social assistance), including funding mechanisms (payroll taxes, general taxes, co-payments).

Figure 1. Distinguishing between outputs and instruments



In clearly distinguishing between policy outputs and the specific ways in which those transfers and services are delivered, we join a previous body of knowledge. Our approach follows Pribble’s (ibid.) superb research on universal reforms in South America. She avoids simplistic dichotomies (universalism versus non-universalism) and focuses on the (gradual) process behind building expansionary welfare policies.

Andrew Fischer (2012) also moves away from oversimplifying dichotomies to distinguish degrees “towards stronger or weaker universalistic principles, along with their equalizing or disequalizing potentials, as well as the institutional obstacles potentially blocking such shifts” (p. 12). His goals are similar to ours: to separate how universalism is defined from specific historical experiences that succeeded in building it; to empirically establish the possibility of building universalism through different instruments and trajectories; and to consider that at a given point in time various social policies may show various *degrees* of universalism.

Universal outputs do not automatically follow from explicit decisions to deliver them: Even in developed countries, generous and equal benefits for all were established over a long period of time. Implementing universal programmes entails financial resources, state capacities and successful veto management. This is why it is relevant that policy makers have a clear sense not just of the policy output they seek to achieve at the end of the road but of the trajectories of change that get there. As recent research on universal health care explains, the road “often uses stepping stones. While some reforms create path dependence, others do not” (Cotlear et al. 2015, p. 6). Still others create path dependency that works against reaching the desired end of the road. Policy makers should make sure that the decisions they make today create (financial and political) incentives for further progress towards more coverage, generosity and equity in the future. Promoting universalism in the long run requires some serious thinking today regarding the trajectories of change that all policies necessarily trigger.

The rest of this paper divides the analysis among policy outputs, a proposed way to consider the combination of policy instruments to deliver them, and the study of trajectories. We conclude with a discussion of the role of the private sector and its management. Along the way, we emphasize the importance of politics in shaping prospects to achieve universalism.

Policy outputs (the *what*): trade-offs among coverage, generosity and equity

So what are universal policy outputs? In answering this question, it is useful to consider the objectives of the much-praised Scandinavian universal welfare regimes. They are characterized by covering everyone with a robust set of equal services and transfers. Rothstein (2008) contrasts this approach with liberal welfare regimes and with those where most benefits are concentrated in some privileged groups according to status. In doing so, he as well as other authors incorporate a strong normative thrust about the desirable aims (see also Danson et al. 2012).

The approach to universalism in Scandinavian countries incorporates specific policy instruments (citizenship-based eligibility, tax funding) and the set of outputs required to redistribute income and expand capabilities. These key outputs are full coverage of equal benefits for everyone. They could be secured through other means; for example, many other European countries do so through social security funded through payroll taxes.

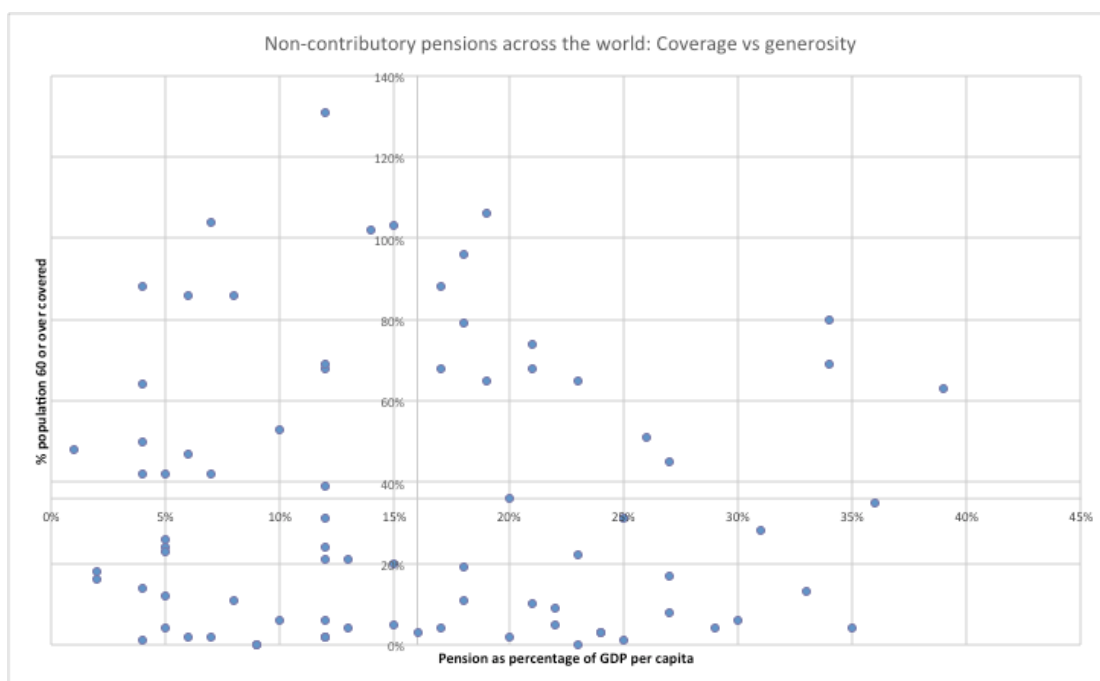
Social policies thus deliver universal outputs when they reach the entire population with similarly generous transfers and high-quality services *independently* of the instruments (e.g., eligibility criteria and type of funding) used. There are three dimensions involved: coverage, generosity (in level and quality) and equity. Few countries perform equally well in all three dimensions simultaneously.³

To illustrate this last point, we compare the variety of non-contributory pensions across the world, considering both coverage and generosity. Although the analysis is incomplete—it does not evaluate equity, for which we would need to include contributory pensions as well—it illustrates the ways different countries deal with complex trade-offs across dimensions of universalism.

³ Other authors have developed similar approaches. Pribble (2013), for instance, focuses on coverage, quality of services and the reduction of segmentation, but also includes transparency and financial sustainability—which we believe are more related to the instruments. Fischer (2012) includes three categories within universalism: access and coverage, costing and pricing, and financing, which also conflate policy outputs and policy instruments.

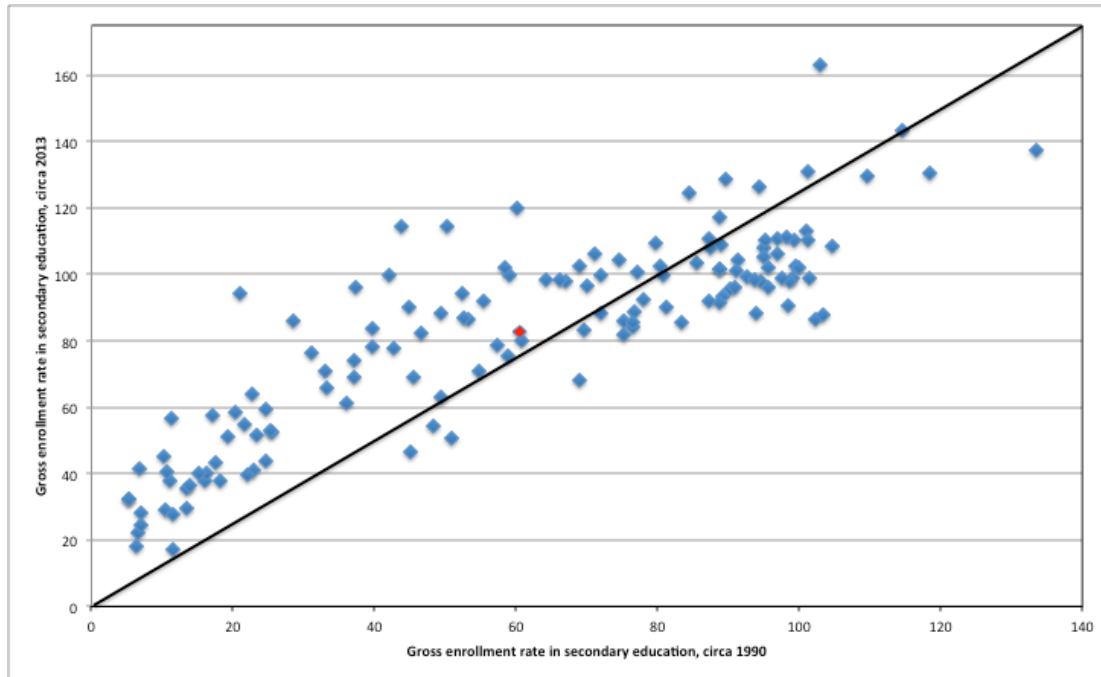
Relying on data for 80 developed and developing countries, Figure 2 uses the percentage of the elderly population covered as an indicator of coverage, and resources devoted to pensions as a percentage of gross domestic product (GDP) per capita as an indicator of generosity for non-contributory programmes. The averages for the sample are 36 percent and 16 percent, respectively, which we use to create four quadrants. There is no clear relationship between coverage and generosity, with countries located in all quadrants. Most of the best performing countries in both dimensions come from the Organisation for Economic Co-operation and Development (OECD) (e.g., the Netherlands with 80 percent coverage and a pension that is a third of GDP per capita) but there are good performers among developing countries as well (like Lesotho and South Africa).

Figure 2. Non-contributory pensions across the world: coverage versus generosity



Source: Authors' elaboration with data from HelpAge 2015.

The weight that policy makers should place on coverage, equity and generosity varies depending on policy realms and historical moments. For example, coverage in primary and secondary education has expanded rapidly across the world: The first has surpassed 80 percent of children of official school age in most of the world—with a large number of countries meeting the corresponding Millennium Development Goal (MDG). Figure 3 reflects the changes in secondary education: Gross enrolment rates increased by more than 25 percent in most of the developing world between 1990 and 2013—gradually converging to developed countries.

Figure 3. Gross enrolment in secondary education, circa 1990 and 2013

Source: Authors' elaboration with data from UNDP.

Notes: For most countries, data are for 1990 and 2013, with a few observations going to 1994 for the initial moment and to 2010 for the final one. Countries on the black line experienced a 25 percent increase in expected years of education between 1990 and 2014. Countries above the line had a higher expansion, while those below the line had a lower one. The red dot represents the non-weighted average of the 139 countries in the sample for the two years.

At present, dealing with quality concerns has become more urgent—and indispensable to improving equity as well. For example, almost half of Latin American students do not reach the minimum acceptable level of reading at age 15 compared to less than a fifth in OECD countries. In Jordan and Tunisia, less than 35 percent of students at age 15 have basic competency in mathematics (Krishnan et al. 2016). Regional disparities are also high: In Argentina, Mexico and Panama, rural students lag by more than one school year in terms of reading when compared to urban ones (OECD 2012). Lack of good teachers and poor infrastructure also contribute to high dropout rates (showing the connections among the dimensions of universalism): 12 percent of children leave primary school and never complete across the world (Murtin and Viarengo 2013). In Ethiopia, the children of Hadia and Sidama origin achieved significantly worse educational outcomes—although some of the explanation is related to lower income levels (Tesfay and Malmberg 2014).

Many recent policy proposals revolve around coverage almost exclusively. For example, in referring to health care, Stuckler et al. (2010) argue that in the South, universal health care is equivalent to universal health-care *coverage*, defined as “the existence of a legal mandate for

universal access to health services and evidence that suggests the vast majority of the population has meaningful access to these services” (p. 2). A similar approach prevails in the post-MDG agenda, which calls attention to a set of services the poor must receive as a matter of right.

Rights-based approaches to social policy share this accent on covering everyone with something, even if basic. For example, ‘basic universalism’ was a notion put forward by Latin American scholars under the sponsorship of the Inter-American Development Bank in 2006. It refers to a set of essential benefits that governments should guarantee to everyone. The amount of benefits at a specific moment in time will depend on the state’s fiscal capacity, and the level of social and electoral support (Molina 2006). Essential transfers and services are those most capable of reducing inequality by redistributing present and future income: primary education, preventive medicine and old-age monetary transfers. Targeting has a role to play in narrowing gaps and ensuring access for all (Filgueira et al. 2006).

The social protection floor shares a similar rationale: It proposes to begin with essential services and transfers for the poor. A commission led by Michelle Bachelet elaborated the proposal, defining a basic floor as “an integrated set of social policies designed to guarantee income security and access to essential social services for all, paying particular attention to vulnerable groups and protecting and empowering people across the life cycle” (Bachelet 2011, p. 23). It initially included a range of social services such as health care, water and sanitation, education, food security and housing, but its scope was narrowed to essential health and income security in ILO Policy Recommendation 202. By 2012, it had gained the support of the United Nations, the World Bank, the Group of 20 and many international non-governmental organizations (Deacon et al. 2013).

The rationale of the social protection floor is also behind the Sustainable Development Goals (SDGs) approved in 2015. Many of their 169 targets refer to social policies that cover everyone with essential services. For example, Goal 3 includes the need to “achieve universal health coverage, including financial risk protection, access to quality *essential* health-care services and access to safe, effective, quality and affordable *essential* medicines and vaccines for all” (italics added). The ultimate objective of the goals is to “build on the success of the Millennium Development Goals (MDGs) and aim to go further to *end all forms of poverty*” (italics added).⁴

The social protection floor—as well as the other approaches discussed here—constitutes a positive departure from the previous minimalist approach based on compensatory measures in favour of the poor. The social protection floor sees social policy as a matter of right, calling for “the extension of social security that progressively ensure[s] higher levels of social security to as many

⁴ See: www.un.org/sustainabledevelopment/development-agenda/, last accessed 22 August 2016.

people as possible” (ILO 2012, Article 1b). In doing so, it opens a window of opportunity for political and social actors in favour of universalism. Yet the approach is also rather contradictory. First, many of the interventions its proponents praise (like *Bolsa Familia* and other anti-poverty measures) are targeted to small segments of the population. Second, there is an accent on *basic* services and transfers, which may not expand capabilities sufficiently and may be unattractive for the middle class. Third, while stressing the need for national adaptation, the social protection floor is generally unaware of political requirements—a problem shared by the SDG agenda.

The accent on the ‘basic’ and the limited attention to concrete political dynamics and path dependence is particularly worrisome. Unintentionally, the social protection floor risks promoting targeting. Excessive attention to basic services for all can ultimately result in scarce and low-quality services only used by those who cannot afford private options. Moreover, if the social protection floor is not accompanied by strong regulations of private services, it could easily perpetuate fragmented policy instruments, particularly along class lines, a point to which we will return in the fifth section of this paper.

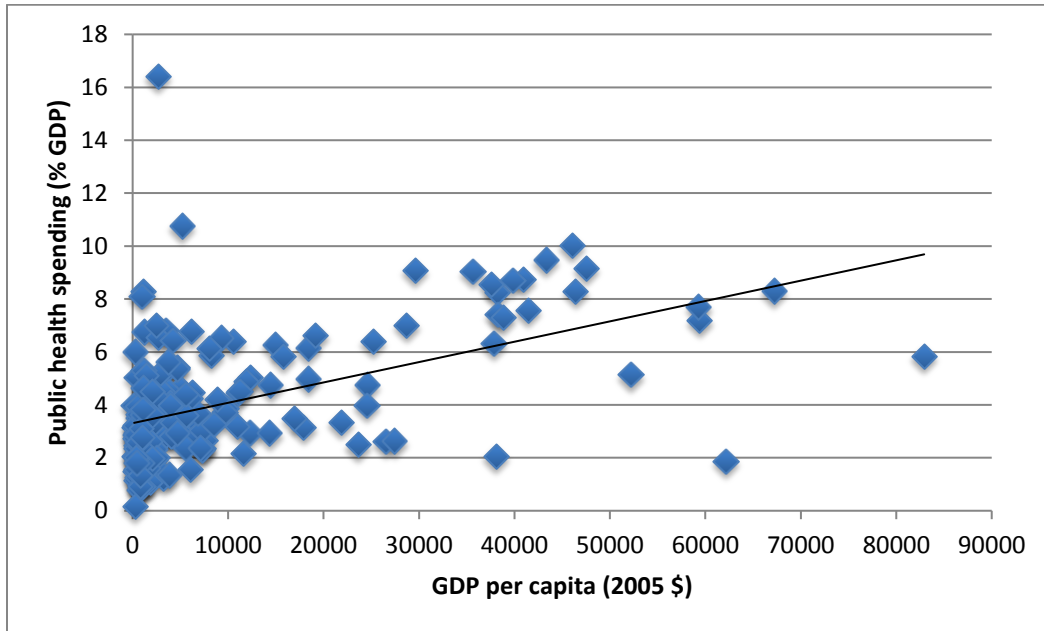
Policy architectures (the *how*): constellation of instruments that deliver more or less unification of benefits

Delivering similar services for all may be desirable, but how likely is it in the South? The constraints are multiple and include insufficient funding, weak state institutions and lack of political commitment. Of these, the lack of resources is often considered the main bottleneck in policy debates.

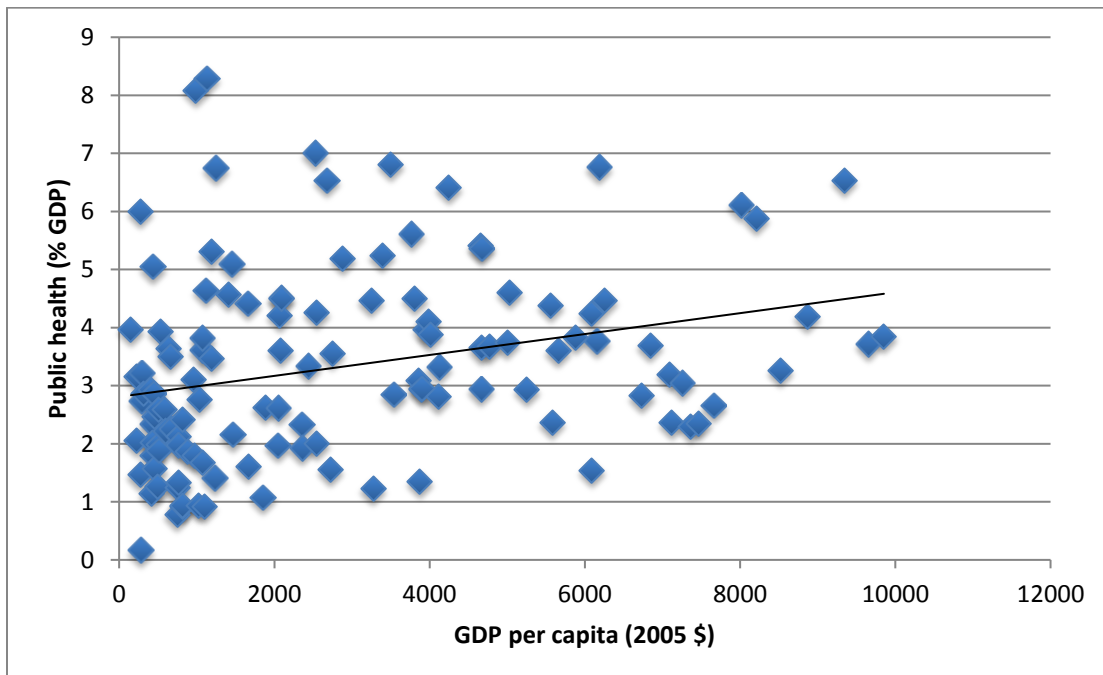
Figure 4 provides a well-known but useful illustration of these limits: health-care spending (as a percentage of GDP) is constrained by the level of income both in the South (here including countries below 10,000 real US dollars per capita per year) and in the world as whole. Governments in low-income countries often lack the means to support large programmes in health, education and pensions that cover everyone like, for example, Scandinavian countries do.

Figure 4. Relation between annual real GDP per capita and public health spending, 2014

All countries



Countries below \$10,000



Source: Authors' elaboration with data from the World Development Indicators.

Of course, this does not mean that only high-income countries can aspire to secure universal outputs, for at least two reasons. First, the level of public health-care spending varies considerably among countries with comparable GDP per capita. Palau spends an amount similar to Djibouti (around 6.5 percent of GDP) despite having a GDP per capita that is eight times higher. Second, higher spending does not always lead to more universal outputs, if, for example, resources are concentrated in a few urban hospitals.

Achieving universalism in the South entails bringing together a mix of tools. Policy makers can benefit from approaching this matter as a puzzle, which varies depending on country context and stages of development. To help ‘solve’ this puzzle, we introduce the notion of the policy architecture. We define policy architecture as the combination of instruments addressing eligibility, funding, benefits, delivery and the outside market options of specific social policies. The architecture is the blueprint of a policy as defined not just by single components but by the interaction among them. Policy architectures can result from explicit efforts of state building and/or from successive policy layers—that is, the incorporation of new elements in an otherwise stable arrangement (Thelen 2004, p. 35)—set in place throughout time.

Policy architectures involve five main components related to who accesses what, when and how (Figure 5):

- **Eligibility (*Under what criteria do people benefit?*):** This dimension refers to who is entitled to receive benefits and under what criteria. The three eligibility criteria studied in the literature are citizenship, contributions and need (Esping-Andersen 1990). Citizenship is associated with belonging to or residing in a given nation state. Contributions are related to the insurance of workers directly and of non-workers as economically dependent family members. Assistance responds to economic need. These three criteria can be displayed alone or in different combinations. They have significant implications for gender equality and the types of gender relations that social policy validates. The more eligibility is defined in individual terms—rather than as a dependent family member—the better. The more eligibility is based not only on paid but also on unpaid work, the better.
- **Funding (*Who pays and how?*):** Financial resources may come from general revenues, earmarked taxes and/or payroll contributions. The last may involve different degrees of financial commitment by government, employers and workers. Any of these funding sources may be complemented by co-payments as long as funding is disentangled from the actual services being delivered. This is particularly beneficial for women—who still in the aggregate have fewer economic resources and are paid less for the same work than

men—as well as for ethnic and religious groups embedded in disadvantaged power relations.

- **Benefits** (*Who defines them and how?*): States generally stipulate benefits in a statutory fashion. Public agencies can do this in a broad range of ways from assuming that all benefits are by default granted, to listing everything included or listing only what is excluded. In some countries, businesses and/or workers also participate in the definition of benefits. The process of defining benefits is particularly important in the face of unequal power relations: Deliveries are organized in a different way when medical expertise and comfort comes first than they are when considering women’s active participation and own comfort.
- **Provision** (*Who does it?*): Delivery can be in the hands of public or private entities and, if private, for- and not-for-profit. Each of these arrangements is driven by particular goals that may favor or inhibit universal policy outputs. These outputs also depend on other factors like efficiency that we will briefly discuss in the sixth section.
- **Outside option** (*How do governments manage market-based alternatives?*): This component refers to the existence of non-public options available to those who can afford them. The existence of market-based alternatives can trigger an exit from state services and transfers (Korpi and Palme 1998). Within the outside option, we not only consider out-of-pocket funded private provision, but also the use of public resources for private gains (e.g., doctors’ conflicting dual practices).

Figure 5. Dimensions of the policy architecture



$E + F + B + P + OO =$ Combined degree of unification/fragmentation

Source: Martínez Franzoni and Sánchez-Ancochea 2016.

Policy architectures influence universalism in two ways. First, at any given point in time, different combinations of policy instruments deliver different degrees of universalism (i.e., the joint combination of coverage, generosity and equity of benefits). For example, the impact on equity of architectures based on payroll taxes depends on the existence of a single fund or a diversity of funds. Architectures based on general taxes will have different effects on universalism depending on what is going on in the other dimensions of the policy architecture. In Mauritius, for instance, an architecture based on the principle of citizenship and funded with payroll taxes has not delivered equity in health care—and has also faced problems of quality—because of the existence of a powerful outside option (Martínez Franzoni and Sánchez-Ancochea 2016). Secondly, dynamically different architectures create distinct opportunities and constraints for subsequent expansion—a point we discuss in the following section.

In the short run, building universalism in the South does not depend on a given funding mechanism or a single eligibility criterion. Instead, the likelihood of universal outputs depends on how effectively policy architectures cope with unifying forces versus pressures towards fragmentation within and across policy components. In comparing different countries, we should thus not focus on individual programmes (e.g., public health care, social security, social assistance for the poor) but on how all of them interact. Ideally, this interaction would lead to unification: independently of founding sources, everyone would then get access to similar, generous services. In practice, there are several challenges to achieving this objective:

- Social insurance systems often provide full benefits to insured workers and a set of more restrictive benefits to their family members. This often has negative implications for women, whose access depends on their link to an insured worker rather than on the recognition of their unpaid work (or informal paid activities). Children often have access to basic primary care exclusively and only until a certain age (for instance, between 6 and 12 in Central American countries other than Costa Rica). In this case, fragmentation operates not only across occupational groups but within families as well.
- People accessing pensions or health care through non-contributory programmes usually receive fewer benefits and of worse quality than participants in social insurance. This can have a particularly negative effect on women. In many countries in the South, they have benefited from the recent expansion of non-contributory benefits but have suffered from the lack of generosity in new programmes.
- A policy architecture that guarantees a small number of services or limited transfers even if delivered as a matter of right may result in fragmentation in usage. Such fragmentation means that people strive to combine different public programmes with non-public ones, each of them with different requirements and benefits.

- Some countries like Mauritius have achieved unification in the first four components, but fail to adequately regulate outside options. As we discuss below, this can increase fragmentation by gradually weakening the commitment of the middle class to public services, eroding the quality of public benefits and/or draining public resources.

A search for unification should be extended to the actual implementation of policies across regions and social groups. Service delivery in health care, education, water or housing varies significantly at the sub-national level, for instance in light of the rural/urban divide or as a reflection of prosperous versus lagging regions:

- In India, in the mid-2000s, 39 percent of children had full immunization coverage—theoretically a right provided by the public sector—in rural areas compared to 59 percent in urban areas. Differences in service provision among states were significant. In Kerala, for example, there was one public hospital bed per 1,299 people compared to one per 20,041 people in Uttar Pradesh. Almost all deliveries in Kerala were attended by health personnel compared to just 27 percent in Uttar Pradesh (Baru et al. 2010).
- According to World Bank statistics, in Tunisia, 30 percent of the inequality in school attendance and almost half of the inequality in access to sanitation is explained by the place of birth (rural versus urban, and region of the country). Geography counts much more than wealth, gender and the level of education of the household head. Similar trends are observed in other Arab countries, such as Egypt and Morocco (Krishnan et al. 2016, p. 63).
- In Sudan, in the mid-2000s, the utilization of antenatal health-care services was five times higher in the urban than in the rural sector (Kronfol 2012).
- In Ethiopia, children of Gurage origins start school almost three years earlier than children from Hadia origins, who also performed worse at age 15 (Tesfay and Malmberg 2014). In Kenya in the late 1990s, some ethnic groups went to school in classes with 13 more children per teacher than others (Alwy and Schech 2004).

Notice that significant subnational variations are not restricted to federal countries but are also present in unitary countries. In Latin America, Chile, where the gaps in human development indicators between municipalities are quite large, is a case in point (Pribble 2016).

Trajectories (the *when*): the order of factors that fuel or deter universalism over the long run

Coming up with fully unified policy architectures that deliver similar generous services and transfers for all and reduce spatial segmentation cannot be done from one day to another; it requires financial resources, personnel, bureaucratic support and enhanced state capacity. One should only consider how long it took OECD countries to secure universalism: Austria and France required more than four decades to provide equal health care for all, something Germany did not achieve until 1992 (Bachelet 2011).

The shape of the policy architecture at a given moment in time depends on the legacies created by previous architectures. There are three significant dynamic roles to consider:

- **Political incentives**. The initial policy architecture will shape “the distribution of power within the policy sector—in other words, emboldening some groups while weakening others” (Pribble 2013, p. 27). In particular, some designs will be more successful in developing the type of cross-class coalitions required to support subsequent expansions. In countries with ethnic divisions, paying attention to this cleavage and to how it shapes the distribution of power will also be relevant. The analysis of political incentives requires considering both structural cleavages, and the political representation and collective action they create.
- **Financial incentives**. Underfunded programmes will become unpopular or will trigger demands for the expansion of revenues. These pressures will be different depending on the initial funding mechanisms (e.g., payroll versus income taxes) and the characteristics of the beneficiaries that are first incorporated. Financial incentives create carrots and sticks for subsequent unification (or continuous fragmentation) of policy architectures. The source of funding, whether national or transnational, tax-based or not, is also relevant.
- **Available reform alternatives**. Policy architectures also constrain the number of possible alternatives that social and state actors can pursue. For example, in countries with a large private sector, governments are unlikely to contemplate a full nationalization of health care or education. In some countries, not-for-profits are part and parcel of state policy, while in others they are totally independent.

Policy makers should be aware of the effects that their decisions will have in the long run. This requires attention to trajectories, that is, the way policy architectures change over time and the iterations that are likely to happen once the first move takes place. Although these iterations do not

unfold mechanically, some trajectories are more likely to contribute to the eventual delivery of universal outcomes than others. Therefore, policy makers ought to draw future scenarios when making initial decisions, seeking to prevent dynamics that fragment architectures.

Below we go over three common trajectories countries in the South have experienced, and assess positive and negative effects for universalism.

TOP-DOWN: THE LEGACY OF BISMARKIAN SOCIAL INSURANCE

Historically, many countries in the South, particularly in Latin America, emulated the European model of social insurance, adopting a so-called ‘top-down’ approach. Building on the principles of full employment and familiarism (Palier 2010a), these programmes offered pension and health-care rights to male workers in specific formal white-collar and blue-collar occupations. In countries with high levels of formality, they gradually expanded coverage to the whole population, even if problems of equity persisted because different occupational groups (and economically dependent women and children) had different eligibility criteria and were entitled to different benefits delivered by a diversity of providers. In countries with high informality—most of those in the South—universalism was out of reach. Households organized around non-salaried and unpaid family work—common in rural and indigenous communities—were consistently excluded (Seekings 2008).

A typical trajectory of these arrangements is summarized in Figure 6. There were at least three problems in incorporating larger segments of the population in a similar way. First, different sub-groups within the middle class had access to different benefits. For example, Uruguay had nine pension funds in 1967, including those for civil servants, and nine autonomous health insurance funds for workers in different manufacturing activities. In exchange for a monthly premium, large parts of the middle class received services from mutual health associations, which spent 3.1 times more per person than the public system (Mesa-Lago 1978). In Chile, social insurance involved more than 10 different funds, with entitlements and obligations contained in more than 2,000 legal texts (Mesa-Lago 1978, Segura-Ubiergo 2007).

Figure 6. Corporatist, exclusionary model

Second, there were limited incentives to extend rights to other groups. Professionals like teachers, doctors, army personnel and other civil servants had no need to incorporate lower-income groups into their programmes. Instead, they exerted pressure to expand the number of benefits they had access to (by incorporating, for example, family allowances) even if this required higher payroll contributions (Mesa-Lago 1978). In this way, the upper-middle class became a blocking coalition that prevented other groups from receiving social services. When this dynamic took place in countries with significant ethnic divisions, the latter fuelled exclusion and, therefore, fragmentation.

Third, dependents of insured workers—most often women—often received lower benefits than men. In most cases, women were granted some benefits, such as primary care and reproductive services, but not others. In addition, their unpaid and care work went unrecognized, so much so that if conjugal relations ended, women’s social protection ended as well. In this system, a married woman would lose her right to a widow’s pension if her husband left her and remarried before dying. Additionally, women in informal or unpaid jobs did not have access to maternity and sick leaves.

Most countries that followed this top-down trajectory incorporated low-income groups through non-contributory programmes that were nominally for everyone in society. In general, these public services and transfers suffered from low generosity (both in quality and type), which reflected and in turn tended to reinforce underinvestment (Cotlear et al. 2015). Politically, in most countries, “marginalized groups continue[d] to be excluded, not only because they lack[ed] class mobilization, but because the existing structure actively reinforce[d] their subordinate position” (Rudra 2008, p. 220). Public services for them tended to deal with ‘recipients’ rather than with subjects capable of voicing demands. Without the support of middle-income groups and without favourable conditions

for collective action of their own, the poor struggled to build the needed political influence to change their lot. The situation was particularly difficult for female-headed households where women lacked formal employment.

Public education services started with the elite and the upper-middle class and later expanded to everyone else. The way to do it was to compromise generosity, particularly in the number of teaching hours per day, which in many countries went from full to part time. Uneven investment in different parts of countries also limited the access of certain ethnic groups to high-quality primary and, especially, secondary education. These groups were further affected by fragmentation in the quality of service providers. For example, in most countries, the most experienced teachers preferred to teach in middle-class urban settings far away from indigenous communities and urban shanty towns.

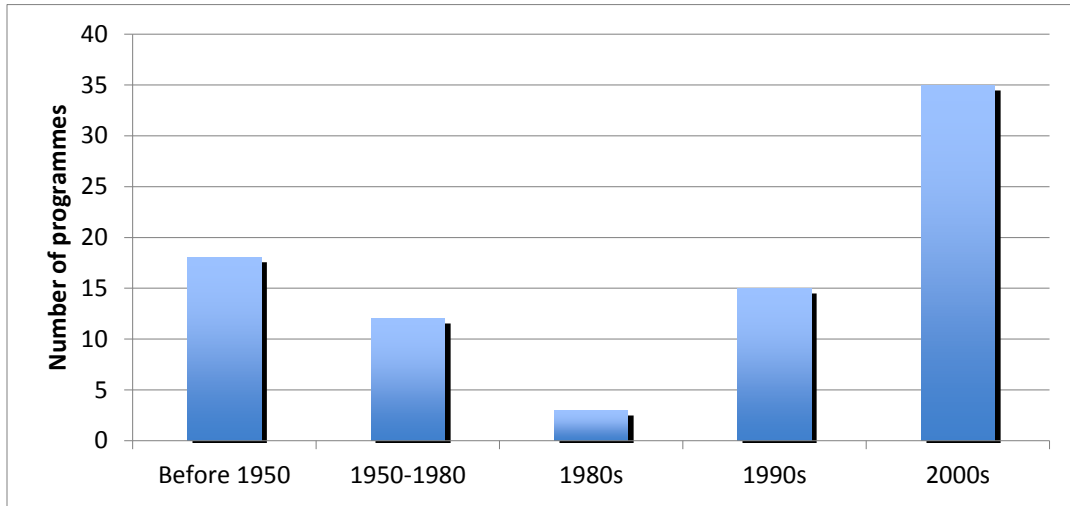
BOTTOM-UP: CREATING FLOORS AND MOVING UP

The recent response to the problems of this kind of fragmented social architecture has been to promote ‘bottom-up’ trajectories. In health care and pensions, this has involved creating new programmes focused on the poor on top of pre-existing ones. In new policy areas like childcare, policy makers have begun by incorporating low-income groups first.

The belief in this case is that countries should focus initially on those groups in need, gradually expanding to other members of the population at a later stage. The social protection floor (and basic universalism) clearly has this kind of trajectory in mind: “The extension of social protection drawing on social floors is of course a progressive and gradual undertaking. Different contexts and conditions will determine how rapidly aspects of the floor can be implemented. However, it is important that there be a phased extension of coverage, with the eventual aim of full coverage” (Bachelet 2011, p. 66).

The strategy of starting from the poor and then moving up the income ladder until the entire population is included has become popular across policy realms. In a recent World Bank study of universal health coverage, 21 of the 24 countries studied had implemented new programmes for the poor that intended to reduce performance gaps with pre-existing interventions (Cotlear et al. 2015). In the case of pensions, non-contributory programmes—most of which target low-income groups—have recently expanded in large numbers. More than 40 percent of the non-contributory pension programmes collected in a recent database were introduced in the 2000s and an additional 18 percent in the 1990s (Figure 7).

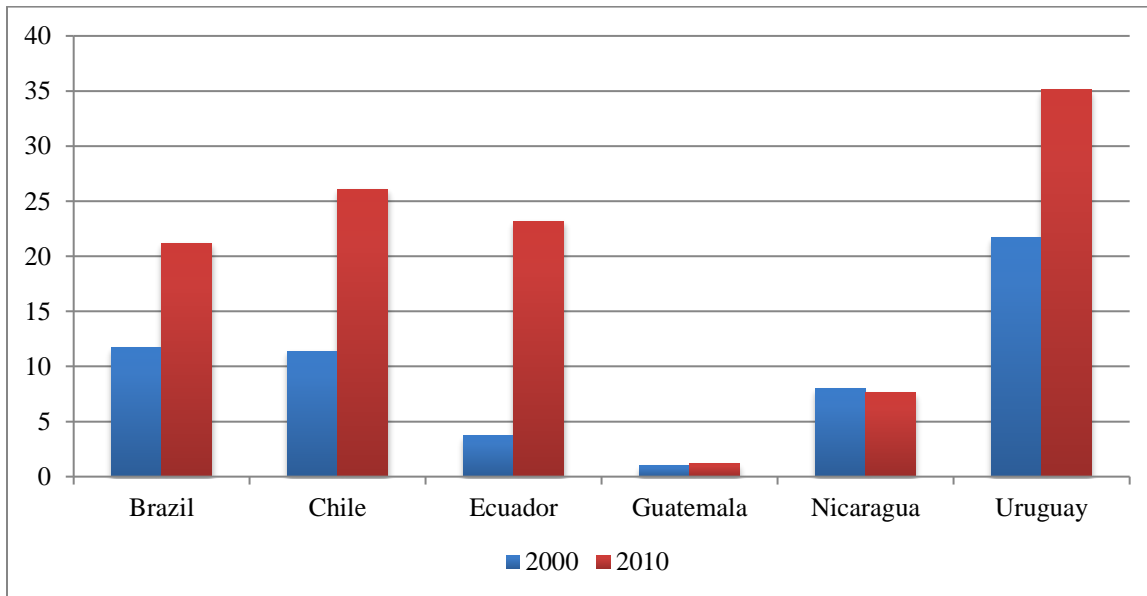
Figure 7. Number of non-contributory programmes per decade of creation worldwide



Source: Authors' elaboration with data from HelpAge 2015.

This approach has also been adopted for new childcare programmes that have expanded rapidly in Latin America and other parts of the developing world. In countries like Brazil, Chile and Ecuador, childcare service coverage of children aged 0 to 3 more than doubled over the course of a decade (see Figure 8).

Figure 8. Enrolment in childcare services among children aged 0 to 3, 2000 and 2010



Source: Berlinski and Schady 2015.

Many of these initiatives aim to deliver universalism through a bottom-up strategy (Martínez Franzoni and Sánchez-Ancochea forthcoming). In Costa Rica, for example, president Laura Chinchilla proclaimed in her 2011 state of the union address that “just as in the past we managed to universalize education and public health care, we will manage a universal integral attention to our young children” (Presidencia de la República 2011, p. 9). This was to be done by starting from low-income groups and subsequently expanding to other groups in society. In Uruguay, the National Care Plan adopted the principle of ‘progressive universality’: Starting from poor children, it aims to incorporate all children at three years of age and a majority of younger children by 2019 (SNC 2015).

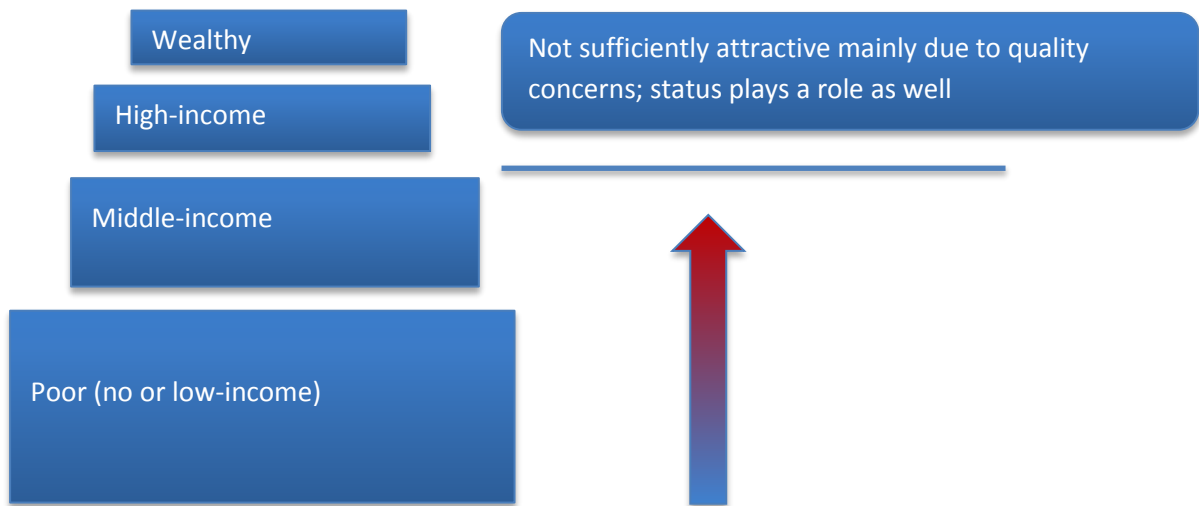
Proponents of this trajectory towards universalism highlight several strengths (Cotlear et al, 2015, Filgueira et al. 2006):

- Programmes should start from those who most need them, trying to reduce the benefit gaps between the poor and other social groups.
- It is easier to begin with a small number of benefits that can later be expanded than to promise everything from the beginning and cutting later. In the case of health care, a recent study argues that “starting narrow and then broadening (from targeting the poor to broader population coverage) is relatively easy to do; starting broad and later narrowing (from having a wide benefit package and then curtailing items) is far harder” (Cotlear 2015, p. 192). In the case of childcare, resources have initially been devoted to part-time services for people unable to rely on market services.
- Funding constraints should be placed at the heart of any expansionary strategy. If benefits are nominally generous but funding is insufficient, countries will be forced to ration through waiting lists, geographical selection of schools and other mechanisms that introduce de facto differentiation of benefits (e.g., better performance among higher-income groups) and/or lack generosity across the board.
- Trying to fund programmes with a combination of payroll and general taxes can create negative incentives in the labour market. Ideally, countries should start from the bottom through non-contributory mechanisms and gradually incorporate social insurance in this system (Levy 2015).
- The introduction of non-contributory programmes can be particularly positive for poor women. In Latin America, they especially benefited from the creation of conditional cash transfers and, on a smaller scale, non-contributory pensions. In 2013, 132 million Latin Americans had access to the former and about 11 million to the latter—most of the beneficiaries of both programmes were women.

Yet the bottom-up strategy also has significant shortcomings, as reflected in Figure 9. Services for the poor tend to become poor services, and are therefore insufficiently attractive for other social groups. Starting from the bottom of the income ladder is also unlikely to generate financial and political incentives to incorporate others. On the one hand, the middle class is likely to avoid services perceived as tailored for the poor, preferring to use market options instead. For example, in education, despite the clear expansion of social investment in public schools for all, between 2003 and 2011, private enrolment in Argentina went from 22 percent to 39 percent (Güemes and Paramio 2014). On the other hand, sooner or later the upper-middle class is likely to oppose services that only benefit other groups. The more the income inequality and the stratification of a country, the more likely these problems will happen. In countries like Guatemala, where poverty and ethnicity are interlinked, and discrimination is rampant, these programmes will remain underinvested in (Programa Estado de la Nación 2011).

Focusing on the poor risks pushing large segments of the population to the private sector—thus never creating sufficient social pressure towards unification of services. In fact, even in OECD countries, a majority of the upper-middle class relies on the market: In 2010, 50 percent of children and youth of families in the highest income quintiles went to private primary and secondary schools, against only 4 percent to 6 percent among the lowest-income quintile (Daude 2012).

Figure 9. Bottom-up trajectories



The conditional cash transfers that have targeted poor women from the beginning create two problems for gender equality. First, women receive these benefits not based on their own right but as mothers (Molyneux 2007). The focus on children means that women's eligibility for social programmes is temporary rather than permanent. Second, transfers are conditional on school

attendance and medical check-ups, which women are most often in charge of enforcing. In this way, conditions reinforce traditional sexual divisions of labour, with men working in paid jobs and women in charge of unpaid domestic and care work.

LOWER-MIDDLE UP AND DOWN: THE IMPORTANCE OF UNIFICATION FROM THE START

There is a third trajectory that a few countries have adopted and that can theoretically deliver equitable advances in coverage and quality. As reflected in Figure 10, this is one that starts with a unified system (e.g., social insurance with a single fund) that initially covers non-poor but vulnerable people (e.g., formal workers with low wages) and later expands upward and downward. In doing so, the risk of creating different programmes for the poor and the non-poor can be avoided.

Figure 10. Lower-middle up and down trajectory



Costa Rica's experience probably constitutes the best illustration of this trajectory. During the second half of the 20th century, Costa Rica became “the closest case of a universalistic, egalitarian social state...” (Filgueira 2007, p. 144) and the only one to “accomplish universalization of social-security coverage, integrating social assistance with social security” (Sandbrook et al. 2007, p. 40). This was rather unexpected since in the 1930s, Costa Rican social policy was underdeveloped and living conditions were not better than those found in neighbouring countries. A majority of the population lacked running water, sanitation and education (Rosero-Bixby 1986) and at 159 infant deaths per 1,000 live births, infant mortality was higher than that of Ecuador, El Salvador or Mexico. By 1960, however, remarkable transformations had taken place in basic services, and Costa Rica outperformed Ecuador, El Salvador and Mexico with an infant mortality rate of 87 per 1,000 (Hytrek 1999).

Behind this success was the creation in the 1940s of a policy architecture for health care and pensions based on social insurance. Three characteristics facilitated pro-universal expansion:

- It first incorporated blue-collar urban workers who could exert voice but were not powerful enough to prevent the expansion to others;
- It was a unified system with everyone under the same programme; and
- It was funded through payroll taxes at a time when other resources were not available.

How did this foundational policy architecture shape incentives for subsequent expansion? Table 1 illustrates the main mechanisms. Since the programme started from lower-middle-income groups, from the onset, Costa Rican workers who were already insured had incentives to support further expansion to higher-income groups who would bring larger tax contributions. This became evident in the 1970s when the government proposal to incorporate higher-income groups was supported by unions across the political spectrum.

Table 1. Trajectory of expansion in Costa Rica

Policy feature	Problem/opportunity	Consequence
Bottom-up expansion of mandatory social insurance for salaried workers	Financial constraints to meet the growing demand for services	Leads to lifting and eventually eliminating wage ceilings
	Most workers already insured would benefit from vertical expansion	Most workers and trade unions support the elimination of wage ceilings
Creation of a top-down unified system under a single agency	High investment in new medical facilities	In the absence of competing private services, the white-collar workers and the better-off had incentives to join the system
Payroll taxes as primary funding source	Effective income-raising mechanism	Further expansion was managerially easy even to fund non-contributory access

Source: Martínez Franzoni and Sánchez-Ancochea 2013.

The provision of the same high-quality health-care benefits for everybody insured (whether workers or their dependent family) created incentives for higher-income outsiders to join. As social security built new hospitals, its facilities became the newest and best funded and equipped. Coverage of the economically active population was 10 percent in 1944, 18 percent in 1945, 23 percent in 1950, 25 percent in 1960, 38 percent in 1970 and 54 percent in 1975. Coverage of the total population went from 12 percent in 1955 to 65 percent in 1975 (Rosenberg 1979, own estimations). By 2000 coverage surpassed 90 percent, and the 10 percent remaining out of the system were mostly the wealthy (Martínez Franzoni and Mesa-Lago 2003).

The Costa Rican path towards universal pensions and health care was also politically easier than one based on general taxes because payroll contributions were relatively easy to collect and harder to oppose. This is an important matter when considering the feasibility of different programmes and the ways to confront fiscal shortcomings. Payroll taxes expanded steadily among the paid workers—first salaried workers and latter also the self-employed, initially voluntarily and later mandatorily—but also funded other important components of the social policy regime (including professional training and non-contributory pensions). The total contribution to health-care insurance alone started at 7 percent of the gross wage and increased to 10.5 percent in 1965 and 16 percent in 1982. Meanwhile, expanding general taxation proved much harder—like in many other countries in the South—due to strong opposition to direct income taxes; by 1970, Costa Rica’s tax burden was just 12 percent of GDP compared to 15 percent in the poorer Dominican Republic.

The lessons we would like to draw from the Costa Rican case do not refer to a specific design but to a set of general guidelines. Probably the most important is the search for unification from the very beginning. Unification takes place when all beneficiaries receive the service or cash transfer in a similar fashion and the state plays a major role in defining benefits, acting as direct provider and effectively regulating the market. Creating public services that are not stigmatized can facilitate a subsequent expansion to all social groups.

Unification of all components of the architecture should also lead to the same benefits for all members of the household. This can be done through two different channels. Ideally, the state would recognize the contributions that some members of the family—usually women—make to unpaid care work. These members would thus be fully insured in terms equal to those of formal workers. As a second best, all members of the household could initially enter as dependents, but always with the same benefits as the formal worker head. This is exactly what happened in Costa Rica, when in the late 1950s, dependents became beneficiaries with exactly the same services as those contributing directly. More recently, the self-employed have also received access to maternity and sick leave. This is a measure that significantly benefits a large proportion of low- and middle-income women who struggle with long hours of both paid and unpaid work.

Of course, as this paper addressed earlier, the risk of this kind of path is that the poor remain excluded. This is why thinking hard about where to start is a second important guideline. In the Costa Rican case, incorporating first the lower-middle class created incentives for subsequent expansion upward and enough resources to incorporate the poor as well. Other countries may try to search for ways to begin with specific groups of the poor and the middle class—trying to create as much mixing as possible. For example, in the case of childcare, this may require building facilities in middle-class neighbourhoods but creating incentives for low-income groups to attend as well. In countries with deep ethnic divisions, it will be important to create stakeholders in the different communities and avoid the identification of services with specific groups. In doing so, we can learn from the trajectory of the approach to gender over time. Signatories of the UN Convention on Ending All Forms of Discrimination Against Women (CEDAW) have begun to move from policies that formally discriminated against women to gender-neutral policies by, for instance, reforming laws that prevented women from entering certain jobs such as those requiring heavy lifting, night shifts, ‘hazardous’ conditions or ‘morally inappropriate’ or ‘socially harmful’ tasks (Assi et al. 2014). Yet this did not eliminate informal discrimination, thus demonstrating that formal equality is necessary yet insufficient for substantive equality. To achieve the latter requires a broad array of affirmative action measures (UN Women 2015).

The last important guideline refers to the convenience of linking services to funding sources. This way growing demand for services will come together with more income. Otherwise, countries run the risk of developing underfunded programmes that cannot be effectively expanded over time.

WHAT ARE THE BEST POLICY ARCHITECTURES FOR UNIVERSALISM?

What should be the characteristics of the initial policy architecture in new areas like early child education and care? In the case of policies already in place, how should policy makers reform pre-existing architectures? In this section, we have identified two potential trajectories: one that focuses on the poor exclusively and another that tries to incorporate segments of the middle class from the very beginning. This distinction is also at the heart of recommendations by the Lancet Commission Global Health 2035, which sees two main paths towards universalism in health care (Jamison et al. 2013):

- A tax-funded, defined benefit package, which targets health interventions that disproportionately affect the poor.⁵ This kind of programme—which may exist in parallel

⁵ In countries with deep ethnic divisions and where certain ethnic groups are poorer than others, the allocation of resources should be done in terms of income and not ethnicity. In this way, programmes would never be linked to specific groups and therefore opposed by others (Stewart et al. 2007).

to social insurance or to an expanding private sector—will focus on expanding coverage of basic benefits. Cotlear et al. (2015) propose a sub-type of this modality, calling for ‘bottom-up’ approaches that are fiscally sensible, moderate in terms of benefits and “give preferential treatment to segments that had traditionally been left behind in the expansion of health coverage” (p. 26).

- A more generous package of interventions aimed at the entire population that includes some patient co-payment that the poor will not have to pay. In this case, there will be a diversity of financing mechanisms, including general taxes, payroll taxes, mandatory insurance premiums and co-payments, all as part of a single set of benefits.

In education, programmes focusing exclusively on the poor have often relied on private providers. They include low-cost primary and secondary schools (see discussion below) as well as subsidies to attend private universities—usually with lower quality than public ones—in countries like Brazil.

For economists like Santiago Levy, tax-funded programmes targeted at the poor are preferable and should gradually replace social insurance. In the case of Mexico, for example, this would mean that *Seguro Popular* would become the single programme for the whole population. By eliminating the distinction between programmes for formal and informal workers, this approach could avoid the negative incentives that social security programmes create against formal employment. In the case of pensions, countries would guarantee a minimum pension to as many people as possible, leaving the rest to private funds.

Is this trajectory actually feasible? Given low tax capacity in the South, this kind of strategy risks insufficient investment, low-quality services and low transfers. In light of these shortcomings, the middle class and the wealthy would likely ‘exit’ the public sector and resort to the market—consolidating fragmentation and thus failing to improve equity. In countries where the poor tend to come from specific ethnic groups (e.g., indigenous peoples in several Latin American countries), this approach will be particularly unpopular.

A better strategy of unification of the policy architecture might be one that tackles benefits and suppliers but maintains different funding mechanisms. Both in health care and pensions, this would require keeping social security and social assistance programmes but with convergent benefits. This has happened in pensions in Brazil, where the maximum non-contributory pension is equal to the minimum contributory one, but separation between the programmes persists. This makes it harder for people to access benefits that may, for instance, combine programmes (e.g., benefits that partially come from contributions and partially from non-contributory arrangements).

At the end, there cannot be one size-fits-all, but context-specific decisions that pursue the maximum degree of unification of the policy architecture attainable at each moment in time. Countries where social insurance reaches less than 20 percent of the population make for a very different scenario than those where social insurance reaches more than 60 percent. In the first case, the best strategy may be an aggressive expansion of social assistance, but with generous benefits and trying to attract as many members of the middle class as possible. Revenues would ideally come from a diversity of sources, including co-payments for those who can afford them, payroll contributions and general taxes. Benefits would not be identified with specific groups (based on ethnicity, race, gender or religion) and ideally incorporate all. Where successful social insurance programmes (or high-quality education in parts of the country) are already present, the challenge will be to unify the benefits different groups receive—something that Uruguay did particularly well (see Box 1).

Box 1. Uruguay: an example of how to unify the policy architecture

Uruguay has been depicted as a “comprehensive social-welfare system” (Haggard and Kauffman 2008, Huber and Stephens 2012) but also as a primary example of “stratified-universalism” (Filgueira 1998) where broad coverage was historically based on a number of different insurance schemes as well as a tax-funded public system (Antía et al. 2013, Mesa Lago 1978). For decades, unifying the different components of the architecture was almost impossible.

Things changed in the late 2000s, however, when Uruguay implemented a reform focused on incorporating all providers into the same system while reducing the gaps between public and insurance-based services. In 2008, a left-wing administration created the National Health System (*Sistema Nacional Integral de Salud* or SNAIS). This effort included mandatory insurance for previously excluded groups: Children and teenagers were to be funded by an increase in premiums and public subsidies (Fuentes 2013). Over-the-counter, direct insurance was eliminated and all revenues channelled to a national health-care fund (*Fondo Nacional de Salud* or FONASA). FONASA transfers resources to providers based on a per capita estimate determined by age and health risks (therefore increasing equity by pursuing the removal of adverse selection). FONASA pays similar amounts to mutual societies and the public provider—thus narrowing the historical inequality of the system. Resource transfers to providers are dependent on compliance with an Integral Benefit Plan.

In 2009, the public sector and health-care providers agreed on a given number of yearly check-ups for people 65 years of age or more without any co-payments (ROU 2012 in Papadópulos 2013). Contributions were made more progressive by differentiating monthly fees according to income levels and the presence of children—fees range between 3 percent and 8 percent of monthly wages.

This reform—which, despite its limitations, has contributed to promoting universalism—was driven by several factors: (a) an economic crisis in 2008 that threatened the survival of a large number of not-for-profit providers, which have traditionally opposed reforms, making a reform urgent; (b) the election of a left-wing administration with close links to trade unions and professional associations, and that was thus capable of aggregating different agendas; and (c) presidential support to a small group of state actors with technical capacity, political connections and bureaucratic expertise.

This group of policy experts designed the reform in such a way that it brought many different actors together, including unions of health-care workers, owners of medical services and mutual aid societies. Particularly important was the middle class, which perceived that the cost of mutual aid services had gone up while the quality of services deteriorated (as reflected, for instance, in waiting periods). Success, however, would not have been possible without the economic crisis. In fact, the Uruguayan experience highlights the role of economic difficulties as windows of opportunity, and also the importance of strategies to improve unification of the policy architecture while coping with features that are too powerful to alter—such as, in this case, the role of private providers and the need to maintain different funding sources.

Dealing with the problematic role of the private sector

Until now, we have primarily focused on the role of the public sector in social provision. Yet private spending is increasingly important in the South. For example, in the mid-2000s, of the 38 countries in the world with private health insurance markets, almost half were in low- and lower-middle-income categories (Sekhri and Savedoff 2006). In education, the United Nations Educational, Scientific and Cultural Organization (UNESCO) estimates that half of education expenditures in countries like Uganda and one-third in countries like Côte d'Ivoire is paid by households (UNESCO 2016). World Bank data show that enrolment in private schools has gone from 10 percent to 20 percent of all primary school students in recent years.⁶

Do private service providers help or hinder the promotion of universalism in the short and long terms? This is a difficult question to answer because of the diversity of private actors and the various public arrangements with which they interact (Morgan et al. 2016).⁷ To address the matter, we propose to take into consideration two different dimensions: the direct effect of private actors in delivering universal outputs in the short run and their role in shaping the policy architecture in the long term.

A large body of literature, particularly from the international financial institutions, has promoted the expansion of the private sector in social services (HDRC/DFID/UKAID 2013; Morgan et al. 2013; World Bank 1993, 2004). Proposals have focused primarily on provision, although

⁶ See: <http://data.worldbank.org/indicator/SE.PRM.PRIV.ZS?end=2013&start=1970>, accessed 7 July 2016.

⁷ The private sector involves a broad array of businesses, including those that provide inputs from medical supplies to teaching materials. Here we focus on providers alone. Even this group is diverse. In the case of health care, for example, McPake and Hanson (2016) identify four types: informal (low quality aimed at the poor); small and medium private practices; the corporate, hospital sector; and not-for-profit providers in different segments. In the case of education, we can also distinguish between the '\$1-a-week school' for the poor, and the formal profit and non-profit services that mostly reach the middle class.

private insurance has often been praised as well. According to different authors, private providers can contribute to all dimensions of universalism: coverage, quality (a central dimension of generosity) and equity.

Private providers can expand **coverage**, particularly in countries with poorly funded states. For example, low-cost private schools have grown rapidly in Asia (India, Pakistan), Africa (Ghana, Kenya and Nigeria) and Latin America (Chile and Colombia), partly compensating for the lack of state supply (Pedró et al. 2015).

They can also contribute to **quality** (Morgan et al. 2016) through several channels:

- Private providers can reach higher levels of productivity and compensate for the weaknesses of the public sector where the lack of competition leads to absenteeism and conflicts of interests. For example, in countries as diverse as Bangladesh, Ecuador, India, Indonesia, Papua New Guinea, Peru, Uganda and Zambia, between 13 percent and 26 percent of teachers are absent on any given day (Chaudhury et al. 2006). The same study found that an average of 39 percent of doctors were not at work when expected. According to other research, public sector doctors sometimes sell drugs that should be delivered for free (Mehrotra and Delamonica 2005) or send people to their private practices. Poor electricity supply is also common across the South. In contrast, private providers are supposed to be more efficient and manage staff better. In the case of education, lower student-teacher ratios and better teaching techniques are behind these positive outcomes (Ashley et al. 2014, Pedró et al. 2015).
- Private providers, including non-governmental organizations, may have more capacity for ‘social innovation’, that is, for implementing novel ideas that deliver a social value beyond profits (Social Services Europe 2012). Private providers have more freedom and incentives to identify new or unmet social needs as well as to develop alternative solutions to problems. Moreover, they can bring a diversity of ideas, and religious and ideological perspectives.

According to some views, private practice can even contribute to **equity**. The expansion of outside private options can reduce the dependence of the middle class on the state, therefore freeing resources for those who need them the most—e.g., building the social protection floor (Jamison et al. 2013).

There are at least three problems with these arguments in favour of private provision, however. First, the evidence of its impact on **quality** is generally inconclusive due to a lack of system-level empirical evidence and to the diversity of the private sector (McPake and Hanson 2016). In health

care, private providers often deliver lower-quality and more expensive services, partly because of their preference for more profitable procedures (Mehrotra and Delamonica 2005). In countries such as Brazil and the Republic of Korea, for example, the excessive number of profitable caesarean sections is an indication of poor quality. In Lesotho, the replacement of a public hospital by a private one—which operates with profit margins of 25 percent—has contributed to spiralling costs (McPake and Hanson 2016). In many other countries in the South, such as Cambodia, China, Ghana, Nigeria, Paraguay and Senegal, health expenditure is increasing at more than 10 percent a year, often without reflecting better services (Montagu and Goodman 2015).

Even in the case of education, where private schools are routinely praised (Ashley et al. 2014, Mehrotra and Delamonica 2005), there are many problems. For example, some private providers that focus on the poor pay little attention to quality: this is the case of low-cost schools, which tend to have poor infrastructure with multigrade classes, unqualified teachers and insufficient regulation (Pedró et al. 2015). In general, the evidence that private schools reach better outcomes is “moderate” (Ashley et al. 2014). Also, some studies argue that higher results in private schools that cater to the middle class stem from the higher socioeconomic status of the parents (CAF 2012).

Second, the private sector often has negative impacts on **equity**. According to a Lancet Commission, although “private financing might be intended to relieve pressure on public spending on health, it can contribute to cost escalation, inequities, and fragmentation” (Jamison et al. 2013, p. 1938). The fragmentation of the policy architecture—which leads to different benefits for various groups—will come from two channels. On the one hand, private providers in state-funded systems will cater to middle-class and wealthy customers, offering them additional services paid out-of-pocket.

On the other hand, the expansion of the outside option provides new choice to high-income individuals but not for the rest of the population.⁸ In education, there is ample evidence that private schools can contribute to segregation and social inequality (Pedró et al. 2015) and leave the poor without quality services (Ashley et al. 2014). The problems created by private providers have been serious enough to motivate a path-breaking UN resolution calling for the regulation and monitoring of private schools—the first time the United Nations Human Rights Council confronted the growing phenomenon of the marketization of education (United Nations Human Rights Council 2015). The resolution recommended measures that protect equity (e.g., access of girls, minority groups like people with disabilities) and also generosity (e.g., minimum contents, operating conditions).

⁸ The expansion of the corporate sector is particularly problematic. According to some estimations in India, the yearly cost of renal dialysis—which includes a profit margin of up to 100 percent—is around seven times the average GDP per capita (McPake and Hanson 2016).

Third, and connected to the previous argument, the expansion of the private sector may erode the political commitment to a unified policy architecture capable of delivering the same services to all. Unfortunately, this political dimension is often missing in technical comparisons between the public and private sector.⁹

In contexts where private providers are growing, the middle class can gradually exit public services. This is evident in countries like Turkey, where the expansion of private providers in health care “has given rise to more socially stratified service consumption. The better-off patients, who can afford higher user fees, have a tendency to leave the public sector and prefer private providers” (Agartan 2012, p. 469). Across the developing world, the rich are the ones increasingly using private options. In Mauritius, for example, more than half of private spending in the early 2000s came from the richest 20 percent of the population (WHO 2006). In Costa Rica, almost 60 percent of all private health-care spending during the same years came from the wealthiest 25 percent of the population (Picado et al. 2003). In the case of pensions, the existence of private funds creates new savings opportunities for the middle class and the rich, reducing their commitment to public plans.

The growing role of the private sector has direct consequence for gender relations through several channels. A large proportion of women across the South still lack an income of their own. In Latin America, despite a sharp reduction in the proportion of these women in the last 25 years, a third of all women still lack an income. In addition, women earn less than men, and when conjugal relations come to an end, they are almost always responsible for their children. The growth of outside options thus places women at a significant disadvantage, which can also affect children significantly.

The expansion of markets also creates new interest groups (such as financial service providers, private hospital owners and doctors in private practices), which have incentives to erode the public sector. These actors can easily become a blocking coalition against universalism, opposing policies that enhance the role of the public sector and reduce fragmentation. Additionally, the growing role of markets in social services weakens state capacity (see Box 2 for the Costa Rican experience). This happens through many channels, including competition for the most qualified and talented human resources and active attempts to weaken the regulatory capacity of public institutions.

The situation may be particularly bad in countries where private providers have always been dominant. In the case of health care, Mackintosh et al. (2016) show how these countries can be locked in a pattern of insufficient public provision and high inequality. In India, a vicious circle of weak public provision and excessive dominance of the private sector contributed to “a sharp increase

⁹ Even authors who call for the study of interactions between the public and private sector in the delivery of services fail to expand that analysis to the political realm (see, for example, Horton and Clark 2016, Mackintosh et al. 2016).

in the role of private health-care provision in the past two decades” as well as “a high and rising” financial burden (p. 4).

Overall the role of the private sector in the promotion of universalism is therefore contradictory. Even when private providers are more efficient than public ones, they can create problems in terms of coverage, generosity and equity. If left unregulated and not incorporated within a national strategy, the private sector will contribute to the fragmentation of the policy architecture and thus to inequality.

How can the private sector be regulated in the South? Blunt prohibition is unlikely to succeed (Montagu and Goodman 2015). Yet the scope for action is large and should take place at different levels. Probably the first and most urgent step is to resolve the shortage of accurate information on private providers. In education, a systematic review of available studies highlights that “there is a lack of data on the true extent and diverse nature of the private education sector operating in the South. What we know about private schools often stems from limited knowledge of ‘registered’ private schools; less-well documented is the scale and coverage of ‘unregistered private schools’, which undoubtedly constitute a large proportion of providers” (Ashley et al. 2014, p. 47). Official records estimate that there are 1 million private schools in the South but the real numbers are much higher.¹⁰ In health care, there are many unregistered hospitals and clinics; the selling of drugs by unauthorized businesses is widespread; and governments ignore the scale of private health-service provision (Doherty 2015, Montagu and Goodman 2015).

Governments should secondly introduce statutory regulation on the types, standards and prices of privately delivered social programmes. This would reduce arbitrary behaviour and unify services across providers. At the moment, eight out of nine clinics and hospitals in a sample of East and Southern African countries lack definition of fees or limits on total charges (ibid.). In education, with the exception of some countries like Ghana, Indonesia and Pakistan (Heyneman and Stern 2013), there is little regulation of tuition and insufficient quality standards across providers.

In regulating the private sector, governments should find ways to incentivize quality improvements and the expansion of coverage while maintaining profits (Montagu and Goodman 2015). For instance, measures may seek to avoid duplication of services (‘certificate of need’); benchmark prices with the public sector; and create state control of fees. East and Southern Africa

¹⁰ In cities like Lagos, there are four times more private schools than shown in the official census. See www.economist.com/news/briefing/21660063-where-governments-are-failing-provide-youngsters-decent-education-private-sector, last accessed 7 July 2016.

are cases in point of what not to do (Doherty 2015). Latin American, where no country regulates dual private and public practices in health service provision, has also followed the wrong path.

Taxing private social services, particularly health and education, could generate new revenues to improve public services. The challenge here is to create the political conditions and public support for new taxes. This will require, on the one hand, a careful selection of which private services to tax—focusing initially on those used by high-income groups—and by how much. On the other hand, state policy must be capable of translating this higher income into higher public income and better quality public services as quickly as possible.

In any case, the types of regulation that are required will vary depending on the specific sector and country context. In situations where private providers are powerful but state capacity is also high, finding ways to unify benefits and avoid co-payments will be particularly important. In education, this will require a single curriculum and more resources devoted to supervisory bodies. In pensions, governments should make sure that public funds always compete with private options so as to keep charges under control and promote real competition. In health care, finding ways to reduce gaps in benefits between private and public provision is particularly important. The Chilean experience is illustrative in this regard. The country emerged from the Pinochet dictatorship in the early 1990s with a dual system. The main public provider had fewer resources, but serviced more people (who also suffered more medical troubles) than the private sector. Ideally, to promote universalism, Chile should have moved towards the unification of providers. Yet given the strength of private interest groups, this was difficult. Instead, in 2004, a left-of-centre administration defined a standard basket of benefits for everyone with the approval of the Universal Access to Guaranteed Rights law. The reform—which had ample popular support (Pribble 2013)—entailed expanding funding for the public sector, overseeing the implementation of guarantees among private providers and reducing discrimination based on health risks.

Policy makers should also remember that the private sector has many faces; often regulating pharmacies or other informal sites is as important as regulating doctors and medical facilities. For instance, in El Salvador, as in other countries in the South, many people resort to pharmacies to solve pressing health problems. Unfortunately, this drains public resources through inappropriate prescriptions and unfinished treatments—partly due to the high costs of drugs—and many people end up in public hospitals with bigger issues to solve. By regulating the price of selected medicines, the General Law of Medicine introduced during a progressive administration (2009-2014) weakened pharmacies while promoting a cross-class alliance among beneficiaries. By making prescriptions for key medicines mandatory, the law also created incentives for more people to get their prescriptions from trained professionals. In addition, regulating access to over-the-counter medicine helped the public sector avoid many health problems that follow from the use of non-prescription drugs.

Box 2. The negative effect of the private sector on Costa Rica's health-care success

Since the 1980s, Costa Rica has witnessed the emergence of three large hospitals and a significant expansion of a few that already existed. Some private hospitals have also created branches outside San Jose and the Central Valley (Muiser and Vargas 2012).

Spending figures reflect the growing influence of private provision: The share of out-of-pocket disbursements went from 21.4 percent in 2000 to 31.1 percent in 2010 (WHO 2012). Although still small, the supply of private insurance has expanded rapidly as well (Muiser and Vargas 2012). This trend was initially driven by the economic crisis of the 1980s.

In addition to creating fragmentation (with high-income groups abandoning their commitment to public health care), the expansion of the private sector has had two other negative effects. First, it has contributed to the expansion of dual practices by doctors in the public sector. Conflicting dual practices take place when public professionals work less than required or act strategically to maximize private gains. This has resulted in all kinds of undesirable behaviour (Clark 2010, Martínez Franzoni and Mesa-Lago 2003). In some instances, doctors may charge patients to jump positions in the waiting list. For example, there are examples of cancer patients being forced to choose between waiting five months for their surgery and paying \$3,000 to receive immediate treatment by the same specialist in charge of waiting lists. In other cases, physicians refer patients from social insurance to their private practice or to private companies in which they have vested interests. Finally, there are cases of doctors using public facilities to attend private patients. Physicians have been known to deliver the babies of their fee-paying private patients in public hospitals.

Second, the expansion of the private outside option will likely have negative consequences for universalism in the long run. The growing number of doctors with vested interests in private practice and of private hospitals is creating a powerful coalition in favor of fragmentation of the policy architecture. Their recommendations include the reduction of procedures offered by the public sector and the expansion of private subcontracting. In the future, the private sector is likely to promote co-payments and incentives for private insurance, and the middle class may gradually support these measures.

Source: Martínez Franzoni and Sánchez-Ancochea 2016.

Conclusions and policy recommendations

Universal social policies should be at the heart of any strategy to promote human development. In contrast to segmented policies—including those based on targeting—universal social policies are likely to guarantee better health, education and insurance against risks for all. By giving these benefits to everyone, they will also avoid stigma and uncertainty. This policy approach will also have social advantages, promoting cohesion and often creating more dynamic economies.

Yet what exactly do we mean by universalism? Much of the social science literature defines it as a set of tax-funded programmes that provide everyone with an equal amount of generous services and transfers. Benefit allocation is based on a single rule of access defined by citizenship.

Using this standard, few countries in the South will create universal social policies any time soon. They face too many obstacles, including insufficient resources, lack of tax capacity and weak bureaucracies. We thus need to develop an analytical and policy approach that delivers the results we want, but through an array of means.

Based on our ongoing research (particularly, Martínez Franzoni and Sánchez-Ancochea 2016), this paper proposes such an approach. We separate the universal outputs from the strategies to achieve both in the short and long terms. To do so, we introduce the concepts of policy architectures and trajectories.

A second contribution of the paper is to link the discussion of instruments and politics. Research on universalism in the South takes place in silos. Political scientists focus on the conditions needed to develop universal social policies. Their recent work has emphasized the role of democracy (Filgueira 2007, Lehoucq 2012, McGuire 2010, Rudra and Haggard 2005, Segura-Ubiergo 2007), progressive political parties (Huber and Stephens 2012, Pribble 2013), adequate economic models (Haggard and Kauffman 2013) and international policy diffusion (Urbina Ferretjans and Surrender 2005). These authors generally downplay the role of policy instruments and their interactions with political variables. In contrast, the abundant expert literature on health care, education and pensions—some of which we have discussed in previous pages—deals with technical issues like funding mechanisms, rules of allocation and principal-agent problems without considering the political implications of decisions about them.

Our approach leads to at least the following six policy lessons:

Universalism is not just about coverage but should also consider quality and equity.

Many so-called ‘universal’ policy efforts have recently focused on expanding coverage. These include low, non-contributory pensions for all and basic health-care programmes to complement social insurance.

We have argued that these new interventions are not truly universal unless they also tackle two other dimensions: generosity (in quality and type) and equity. If everyone has access to some health-care benefits, but only a few have their cancer treatment covered, there is no universalism to speak of. Neither can we call an education system universal when it combines poor-quality public schools with a much better private system. When it comes to pensions, if transfers to the poor are below

subsistence levels while the rest of the population receives generous pensions based on previous income levels, we may witness massive coverage yet not universalism.

Of course, there are always complex trade-offs among the three dimensions: for instance, governments often struggle between expanding the generosity of benefits and increasing coverage. Also, our output-based definition allows for different *degrees* of universalism, depending on the combination of the three dimensions at a specific moment in time. Policy makers should be aware of these trade-offs and come to terms with how to resolve them over time. Ideally, they should also be explicit about where in the continuum they would like different programmes to be.

A related challenge has to do with indicators: to a large degree, coverage pays off politically because it can be easily measured. Policy makers and researchers face the challenge of measuring quality and equity so as to make them visible beyond the level of anecdotes and individual experience.

Universal outputs can be promoted through a combination of instruments.

There may be a diversity of ways to deliver policy outputs in different contexts and policy realms. Countries should creatively combine social security and social assistance and, at times, also accept co-payments from those with enough income. Remittances and international aid can also be important funding sources, which should ideally be incorporated into a national strategy. The key matter is how financial resources help support a system rather than a set of scattered programmes. To consider possible combinations, we introduced the notion of a policy architecture, which includes eligibility, funding, definition of benefits, providers and the private outside option.

When discussing changes in the architectures, experts and policy makers tend to focus almost exclusively on funding mechanisms, exploring the strengths and weakness of contributory and non-contributory systems. The former constitutes a better insurance mechanism (by linking payments and benefits) but can also have negative effects on formal employment. Yet we believe that the other four components may be even more important. In particular, policy makers should look for the **unification** of benefits and suppliers; should adequately regulate the outside option (see below) and may need to accept a variety of income sources. For example, some beneficiaries may contribute with payroll taxes and others benefit from social assistance; the important thing is that both groups have the same core benefits. Even if this kind of unification can have at times negative economic implications (leading to the growth of informal companies), it can be the most pragmatic solution to overcome difficult political constraints.

Universalism will not be achieved from one day to the next; embracing strategies that unfold into the right trajectory is fundamental.

As we recognized at the beginning, securing a fully unified policy architecture capable of delivering the same generous benefits for all will take time. Policy makers should thus be acutely aware of the potential trajectories, trying to find the best direction of change.

There is much debate on where to start to build universalism and what the optimum trajectory should be. In recent years, influential approaches like the social protection floor have proposed beginning with the poor, providing them with basic benefits. In health care, this means introducing a defined basket of preventive and primary care procedures; in education, having a reduced number of school hours per day; and in pensions, providing a low non-contributory pension. According to proponents, this will consolidate the new programmes politically, set a certain level of expectations, and create opportunities for further expansion in coverage and quality when there are more resources available.

Several reasons justify this approach, including weak fiscal and bureaucratic capacity, and high levels of social segregation. Yet this strategy of expansion is also risky. By not incorporating segments of the middle class at the beginning, countries run the risk of never including them. If the middle class identifies the new services with the poor, it may never use them or support them electorally. In countries with sharp ethnic divisions, policies in favour of discriminated groups will often be opposed by others.

In our view, one of the central challenges for policy makers is to promote cross-class and cross-ethnic coalitions that sustain expansion over time. Meeting this challenge requires different strategies in different countries (see next point), but always demands attention to the way programmes are marketed and to the definition of beneficiaries at different times. Departing from services aimed at the poor and then expanding them to the non-poor requires overcoming social barriers among income groups. Assuring generosity of benefits (in type and quality) will help to do so, but may not be enough. In many circumstances, governments should consider how to incorporate the middle class—and how to include a diversity of ethnic groups—from the very beginning.

The identification of desirable/feasible policy instruments and long-term strategies are necessarily country specific.

To be clear, we are not arguing that every country should combine social security and social assistance and begin new programmes from the middle class—even if this is what Costa Rica successfully did. Strategies will also be different in education (where general taxes are important and mixing students from different backgrounds is particularly relevant) and in health care (where social

security can play a prominent role, and the question is how to create complementary eligibility criteria to extend benefits to, for example, unpaid domestic and care workers).

Which strategy is better in different contexts? Unfortunately, much more politically aware research is needed to answer this question. Nevertheless, there are at least four variables that should be considered when making decisions:

- Social structure. Policy makers should be aware of the key cleavages created by the social structure in their countries. Two of these cleavages are relevant everywhere: socio-economic differences (as measured by income and assets) and gender relations. We have referred to the former across the paper. In general, the more social distance there is between classes and the larger the size of the middle class, the more important it is to include this group from the very beginning. Gender relations play a crucial yet different role. The differential role women and men have in caregiving and unpaid work constitutes a challenge to effective social policy design. If the participation rates of women in formal employment are low, social insurance mechanisms that do not include family members will be especially problematic. Likewise, if family dependents have access to less generous benefits, inequalities will increase.
- Gender and social class interact in complex ways, creating additional obstacles to universalism. In Latin America, for example, women with low family income and/or few years of education have lower rates of formal labour force participation than the better off. The combination of paid and unpaid work is also different, with the better off contracting out (mostly informal) domestic and care work to others and thus needing social services less, at least in the short run. Race and ethnicity—often coupled with migratory status—add to the insider/outsider divide, and in many countries shape the supply of paid domestic work. Policy makers should be aware of how to package different policy issues to create cross-class coalitions of women in support of social policy. Additional factors like race/ethnicity and religion may be crucial in some cases yet not in others. In countries like Bolivia or Guatemala, rural areas with a strong presence of indigenous populations tend to rely on traditional family arrangements outside the market economy. There, women play productive and reproductive roles yet all their work is unpaid. They tend to be suspicious of the state partly because of historical reasons but also because it lacks adaptation to culturally sensitive issues (e.g., the gender of physicians, the routines followed in medical check-ups and the language used at schools). Policy makers will need to modify services in these areas, while maintaining support for funding from all groups in society.

- State capacity. In weak states with limited funding capacity, there are reasons to begin with small programmes for the poor; the risk, however, is that they cannot expand coverage beyond low-income groups or ensure quality. This becomes a chicken and egg problem: The lack of state capacity fuels weak social programmes that further weaken support for the state. In these contexts, policy makers have so far failed to respond to the following two questions: How can additional revenues be secured? How can programmes grow hand-in-hand with improved institutional capacity? To resolve these challenges effectively, policy makers may need to secure a diversity of funding mechanisms from the very beginning. It may also be better to start from specific regions of the country—for example, those where people from different income levels coexist—instead of targeting low-income areas alone. Governments and international institutions should also pay more attention to how private practice contributes to creating or weakening state capacity.
- Pre-existing policy architecture, particularly its initial fragmentation. The most desirable reform strategy in each case will be heavily influenced by how well social programmes perform—including those aimed at the non-poor—and how fragmented or unified the policy architecture has previously been. If the poor lack any services, governments will be pressured to make rapid progress to include them quickly. In these circumstances, spending time and political capital creating cross-class alliances will be extremely hard. In contrast, when middle-class individuals are also in need of public policy intervention—for instance, because of the skyrocketing costs of private services—they will be more willing to enter into programmes that are initially for the poor.
- Economic conditions. By increasing labour market flexibility and wage gaps in the labour market, globalization has created new obstacles to universal social policies. Even in developed countries, there is a growing divide between insiders and outsiders, and growing economic constraints to incorporate the latter. Nevertheless, there is still a lot of room for manoeuvre, which has been used by some countries better than by others. In countries where the middle class has experienced downward mobility in recent decades, promoting cross-class coalitions will be easier. In many cases, governments will need to find more creative sources of finance, coming from property taxes and higher royalties on primary goods.

The private sector has to be managed with care: Regulation is particularly important.

Private providers, particularly not-for-profit, can contribute to universalism. In some countries, they may be more efficient than the public sector, helping to reduce absenteeism and promoting

better technologies (e.g., teaching strategies or cost-effective medical procedures). In some instances, they are also more likely to introduce innovations and be more responsive to citizens' needs.

Nevertheless, the participation of the private sector is also risky. For-profit private providers will tend to fragment the policy architecture by offering different benefits to different groups and pushing for users' fees. Effective state regulation is therefore vital. First, information on the number and performance of private providers is crucial—in fact, no effective public policy can operate in a vacuum regarding key actors and services supplied. Second, the state should try to set clear norms in key areas, including fees, characteristics of delivery and a common curriculum. Whenever possible, these measures would try to unify benefits and costs across the board. Third, governments should also eliminate tax incentives that favour private suppliers—who tend to offer services to a minority of the population—and tax them in order to support public services.

Building on the international window of opportunity while modifying the global discourse.

The SDG accent on expanding health care, education and other services to the whole population has expanded policy space in many countries. Progressive policy makers and social movements across the South are already using the global discourse to reject an excessive focus on targeted programmes and residual policies. At the same time, the SDGs and other international discourses like the social protection floor also come with risks. By focusing on basic services and highlighting the needs of the poor, they could contribute to further segmentation of social provision. Our hope is that many of these international efforts embrace a more nuanced approach to universalism, one that recognizes the need to reduce fragmentation in provision and continue promoting alliances across classes, men and women and a diversity of ethnic groups.

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