Inequality and redistribution: analytical and empirical issues for developmental social policy

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Inequality and redistribution: analytical and empirical issues for developmental social policy

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1 Introduction

This short note seeks to address – drawing mainly on the example of health care, and using evidence particularly from the African context – what appear to me to be several key issues in the analysis and design of social policy for developmental and ethical ends. It was prepared in the context of a discussion of a draft UNRISD paper (Mkandawire, 2000). That paper surveyed a number of current arguments for the relevance of social policy to economic development; three of its key points were:

1 that health and education are necessary for growth;
2 that effective social policy can prevent developmentally dysfunctional inequality and conflict; and
3 that we need to understand how these points can be moved onto the political agenda in both authoritarian and democratic regimes without such functionalist arguments undermining the intrinsic importance of social solidarity as an ethical objective.

The paper's implicit definition of social policy was a mix of governmental action to shape social provisioning such as health and education, and government action to shape the distributive outcomes of broader economic development.

This paper began from these points, and considered: the issue of the social construction of the social policy mind-set, underlying point 3; some absences in the social policy and development literature, notably on the topic of redistribution, and some related gaps in theory; and some proposals for relevant elements of a research agenda. Examples and references were limited by length[1]; some draw on the research project referenced on page 2. The arguments put forward are not fully worked through, being put forward in summary form as a contribution to debate.

2 The social construction of social policy

To move from the European social policy literature to the literature on social policy and development is to perceive – or at least so it appears to me – a methodological 'thinness' in the latter. The basis for this perception can be illustrated from the health policy literature[2]. In the development field, the health policy literature is characterized by an emphasis on egalitarian objectives and by repeated demonstration of redistributive failure. However, detailed research on the political economy of these policy failures is much harder to find. Both the dominant policy mindset in the field, and the dominant conception of the policy process in the academic literature, can be characterized as a linear policy formulation to policy implementation model. There are numerous critical voices, but, I suggest, a lack of a solid alternative health and development literature rooted in political economy and social theory.

In this, the contrast with the European literature is rather sharp. European social policy analysis contains strong sub-literatures that relate social policy and process to social structure, and to

[1] These arguments are being developed at greater length for a forthcoming UNRISD publication; the version produced here was the basis for a short presentation and should be read as such.

[2] This paragraph draws on a literature review undertaken with Lucy Gilson, to whom I owe a good deal of my understanding of this literature (Mackintosh Gilson, forthcoming). The use I make here of our joint work is my responsibility alone.

broader political and economic processes. These include historical and comparative work on welfare regimes, and more abstract theorizing of policy processes based in historical analysis[3] ; research on social exclusion that draws strong links between employment and other economic changes and social policy; and the literature I want briefly to draw upon here, on social construction of welfare policy.

The social constructionist literature (for example, Williams, 1989) embeds its understanding of redistributive success or failure in the concept of a 'social settlement': the notion that particular welfare regimes constitute a (temporary) settlement between embedded inequalities and redistributive action. In this literature, social sectors such as health and education constitute arenas that both reflect (and consolidate) particular patterns of social inequality and offer an effective stage for challenging inequity[4]. 'Settlements' are periodically broken up and reworked. Methodologically, the social constructionist work – like some of the social exclusion literature – seeks to bring together analysis of the discursive construction of identities in relation to state and economy with analysis of social and economic structure. Its strengths include a generalizable methodology that requires context-specific analysis.

This methodological approach has also proved useful to scholars in middle and low income countries undertaking historical and sociological analysis that tackles inequality and exclusion, and social and economic policy. Kaijage and Tibaijuka (1996) argue, for example, that the social exclusion framework is methodologically attractive because it combines an emphasis on understanding individuals' experience of marginalisation through economic deprivation and social isolation with an understanding of the context of that exclusion in social and economic divisions and in policy interventions[5]. As another example, more historical work on the social construction of welfare regimes might shift our perceptions of the East Asian welfare model: a recent detailed study of the emergence and operation of the Japanese health care system (Campbell and Ikegami, 1999) contradicts the image of fragmentation and regressive distributional effects suggested in Mkandawire (2000: 20), demonstrating instead the strength of central government bureaucratic control and the large-scale progressive cross-subsidies embedded in a system nevertheless institutionally differentiated by employment status. We need much more work on non-Western social sectors that combines detailed economic analysis of distributive processes and outcomes with historical and sociological analysis of the interaction of social sectors with the broader economy and polity.

At present, the opposite approach could be described as dominant in the social policy and development literature, at least in health care: a prescriptive approach that separates redistribution from production in theory and social policy. This policy mindset is in part the product of market liberalization itself in social sectors such as health. Marketization tends to expose and drive out cross-subsidy in industrial and service sectors, generating an institutional split between provision through exchange and redistribution via government that has its origins in economic theory that takes market competition as a theoretical yardstick. This institutional evolution thus generates an analysis of the scope for redistributive policy that focuses on elaborating prescriptions for 'targeting' government and aid funding to the poor, rather than on shaping the distributive outcomes of the mixed public-private social sectors as a whole. The

[3] An example of the latter is de Swaan (1988).

[4] Lewis, 1996; Mackintosh, 1996; Hughes and Lewis, 1998 apply these concepts to the UK.

[5] See also the papers in Semboja and Therkildsen (1995).

rest of this note considers some aspects of the scope for building a more contextually based analysis of redistribution in the social policy and development literature.

3 Theorizing co-operation and redistribution

Institutional economics has had a considerable impact in recent years on the way economists theorize economic behaviour in communities and markets. The aspect of this that concerns me here is the explosion of work on collaboration and trust. Using game theoretic approaches, the new institutional literature has focused extensively on the incentives for co-operation and the causes of its breakdown. A common analytical conclusion is the greater ease of sustaining co-operation and reciprocal trust in small communities with repeated personalized interactions than in large-scale impersonal interactions (for example, Bowles and Gintis, 1998). These analyses of reputation effects and social capital, in the form of personalized networks, underpin, in theoretical terms, the policy shifts towards decentralization, co-production and community involvement in the social policy literature in the West and in the development context.

Much less explored in the social policy and development literature – for related analytical and theoretical reasons that bear examination – appear to be the conditions for effective redistributive behaviour by governments, service providers, funding institutions and communities. That problem seems indeed practically absent from policy debate. Again, I use health care as the example. The new institutional economics is used in the health policy literature to demonstrate the importance for health care quality of sustaining professional ethics[6]. The health policy and development literature has a strand focusing strongly on the importance of community initiative, including projects involving community health workers. This emphasis on co-operation and community has tended to obscure the sharp divisions within communities that block co-operation, and to obscure the frequently perverse redistributional effects that emerge from community-based schemes. A recent literature review concluded that while co-operative ethical behaviour – between health care professionals and between staff and patients – clearly has a positive effect on quality of care, there is no necessary relation between collaboration and redistribution (Mackintosh and Gilson, forthcoming). Indeed there is a theory-driven confusion in the health policy and development literature between collaboration and equity.

Theoretical and empirical research in health policy and development therefore needs to pay more attention to the social, political and institutional conditions for sustained redistribution, indeed to bring that problem back to centre stage. To do so involves much greater attention to the scope for the poor to make legitimate claims on service providers, which in turn involves the scope for organization and the exercise of power to make entitlements effective. It also involves much more attention to legitimacy: to the ways in which redistributive action is legitimated in unequal societies. Sustaining progressive redistribution is difficult in unequal societies, given the power and desire of elites to accumulate resources; however, unequal societies' elites differ in their redistributive behaviour, and these differences are related both to political process and ideology and to culture and institutions.

It is the latter issues, those of culture and institutions, that I want briefly to pursue here[7]. If we define 'redistributive' behaviour to encompass all social processes that create increasingly

6 Indeed I have done that myself (Mackintosh, 1999).

7 Processes of power and organisation are crucial too, but these issues are not pursued here.

inclusive or egalitarian access to resources – in this example, effective claims to decent and humanly respectful (rather than abusive) health care provision – then empirical observation of successful redistributive behaviour in health care suggests the following working ideas.

First, sustained redistributiveness is achieved when redistribution is embedded in legitimate, reciprocal and 'naturalized' social relationships[8]. Thus, the Western European and Japanese universalist health care provision – whether institutionally and discursively constructed as 'social insurance' or 'public provision' – embeds high levels of redistribution in socially inclusive insurance mechanisms; this mix seems likely to explain the social sustainability of the systems[9].

Second, health care access and redistributiveness have been developed and sustained where rights to health care as an element of citizenship have become an arena for political competition: the process is well documented for Kerala state and for Taiwan, two very different contexts in which access to health care is very widespread and redistributive in its effects[10].

Third, highly inclusive and redistributive health care systems have historically been built up – in very culturally specific contexts – from patchworks of public, mutual, charitable, employment-based and private provision, through political processes at the national level. Conversely, systems dominated by private fee-for-service provision are extremely hard to generalize: in addition to the US, South Korea provides a good case study of this problem; there, the large co-payments established in the private system still effectively exclude large numbers from the supposedly universal provision (Yang, 1996). Systems that are not highly socially segmented, and not dominated by private care, are easier to universalize.

Fourth, we should not expect too much redistribution to occur within small communities. This is where the focus in the institutional research literature on personalized networks and the collaborative strengths of poor communities becomes problematic. There are some circumstances where small communities can play a redistributive role: Gilson *et al* (1998) describe one of these, the Thai low income card, awarded by communities to their most indigent members. But these awards are made on strong nationally-set criteria. More generally, institutional and anthropological theory would lead us to doubt that personalized relationships are a good basis for redistribution, since theories based on different methodological premises suggest that unreciprocated gifts are hard to sustain. Individualist game theoretic analysis would lead to the expectation that altruistic behaviour would tend to be undermined if not embedded in reciprocation; less individualist institutional theory argues that gifts imply relations of dependency, and to be sustained need to be embedded in legitimate and 'naturalized' social relationships[11]. It follows that larger-scale, more impersonal rules, legitimated through social and political processes, may be central to redistribution.

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8 This argument draws on the analysis of institutions in Douglas (1987) and is made in more detail in Mackintosh and Tibandebage (2000).

9 Barr (1993) and Besley and Gouveia (1994) make this point for European systems.

10 Narayana, 1999, discusses Kerala; Dreze and Sen (1995) make this point for India, comparing the presence or absence of such competition over health care in the politics of different states with the observed health care provision; Chiang (1995) analyses the political party competition around health care universalization in Taiwan.

11 Bowles and Gintis (1998) is an example of the huge literature on the sustaining or undermining of 'pro-social' behaviour in a game theoretic framework; anthropological analysis of gifts from Mauss (1924) onwards emphasizes their role in creating relationships of reciprocity and dependency.

Finally, redistributive action – including health care – has historically been tightly involved in nation-building and the construction of concepts of citizenship. Welfare systems construct and are constructed on notions of who is and who is not a full citizen. Hence, they exclude and stratify, in the UK, notably, by 'race' and gender as well as social class (Williams, 1989; Lewis, 1996): welfare systems are thus the bearers of broader social relations of inequality. However, they are also a political 'stage' for the constitution and contestation of notions of 'the public', and are thus important building blocks of legitimate democratic states.

Social polarization and redistribution

The redistributive commitment of the state and the government is an endogenous variable: it is deeply influenced by the general patterns of social class, inequality and exclusion in society, and also by the particular institutions of social provisioning. Behavioural influences run in both directions, from social provisioning systems to government distributive behaviour and back. African scholars and health care practitioners point out that liberalization of private provision, with its implicit legitimation of inequality within the system, is not likely to be associated in practice with *rising* government commitment to redistribution, although this is implicitly or explicitly assumed in many reform strategies for African health care, all of them very strongly driven by donor agendas[12.]

More generally, there is no available justification that I know of, in the research literature, for the underlying assumption of much recent multilateral writing on social policy that targeted public provision is the way to achieve greater inclusion. There is likely to be – on the contrary – a positive association between means testing and inequality: while cross-section correlations between countries are inherently problematic, that hypothesis would bear further exploration. The two alternative 'visions', much more explicitly addressed in the European than in the development literature, of the state as gap-filler and the state as a major player in the shaping of the system as a whole, need revisiting and debating explicitly in current development contexts. A (crude) hypothesis might go: highly polarized mixed systems of provision tend to be associated with highly regressive elite-focused state behaviour, while more inclusive mixed systems – where access is a publicly debated issue, cross-subsidy occurs, and different social classes come across each other in the same institutions – is likely to be associated with more progressive state behaviour.

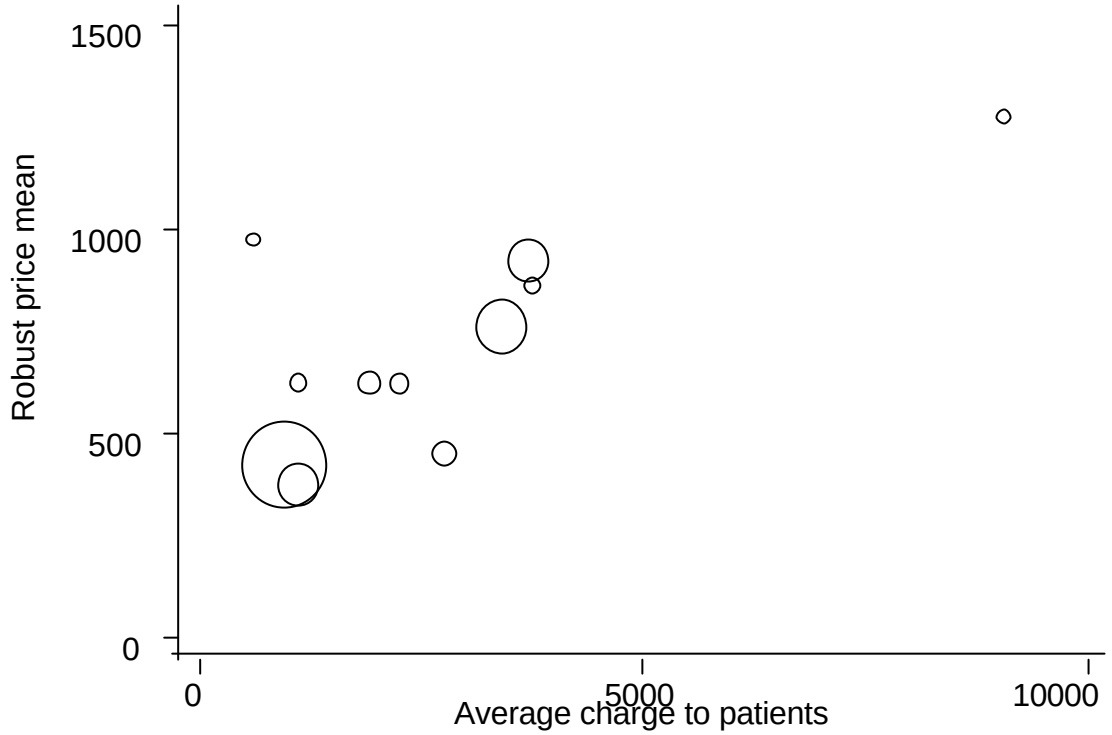
The issue is extremely timely. Liberalization of formal private provision of health care in many African countries has reshaped existing health care markets, and created implicit choices about the direction of private health care market development. Social polarization in some systems is limited but consolidating, facing governments with clear choices of policy framework. As just one illustration, Figure 1 is drawn from recent research in Tanzania[13]. The circles are primary care providers in all sectors in Dar es Salaam; the size of the circles is weighted by activity level; the two axes show two independent measures of charging levels, mean stated facility prices and mean charges to patients leaving the facility. Two poles of activity with different charging levels

12 Quoted in Mackintosh and Tibandebage (2000), see also Kalumba ,1997.

13 See the acknowledgements on page one; this field research was designed with Paula Tibandebage, managed and directed by her; and undertaken by her, myself and other Tanzanian researchers. The use I make of it here is my sole responsibility.

emerge: these are small sample data, but the qualitative evidence supports emerging, but still incomplete social segmentation of the market.

Figure 1: segmentation in the Dar es Salaam primary care market



In circumstances such as these, government action within partly polarized systems will help to shape the scope for future integration. Governments do not only fund care; they also actively shape the institutions that emerge in the market. For example, many African countries do not have functioning 'social insurance' schemes for public and formal sector employees. Government support for their establishment, which is widespread, has been argued against on the grounds that it further entrenches social differentiation. On the other hand, if such systems operate to prevent the emergence of personal private insurance and fee-for-service middle class provision, and if they can be used to shape the quality of care in institutions that also serve others, then they might help to prevent worse forms of polarization. Other forms of social action also shape the systems. For example, mutual systems of saving for health care may be only very mildly redistributive within themselves; they may, however, play an organizing role, helping groups to act collectively in relation to health facilities on which they rely, especially if their organizations can gain professional support to help them to exert pressure on costs and quality (Kiwara 2000).

The general points are two: the levels of social polarization and regressivity differ sharply between different mixed private/public health care systems, and we need to understand more about the institutions that shape these differences; and second, we need more work on ways in which governments and other organisations in low income contexts can constrain and reduce polarization. Donor policies that try to *exclude* governments from these activities are likely to have strong negative effects on government capacity and commitment.

Finally, we probably need simply more empirical research on mixed health care systems treated as 'industries': the kind of context-specific research on health care market behaviour that is commonplace in high income contexts. Research on the private sector in health care has been increasing in the development context, but this has yet to feed back into theorizing and policy towards the systems as a whole. Some of the most important influences on exclusion and abuse of the poor within health care systems lie in pricing policies and the shaping of health care transactions. We need much more explicit research and writing on how to value and sustain cross-subsidy, charitable provision, and competent provision free at the point of use in low income contexts. There are good examples of all of these in African contexts, but their legitimacy has been challenged and their achievements denigrated, and the questions have been squeezed out of the research literature by the policy mindset discussed above.

One element of needed research is more exploration of how diverse groups of people can establish and sustain effective claims to competent social provision. Effective claims to health care are both a social asset for the poor, and draw on and reinforce other social assets such as education and income earning opportunities. Such effective claims are not individual assets, even when exercised predominantly through a market exchange. The Tanzanian field research discussed above made abundantly clear the social shaping of the terms of exchange in health care, not just in terms of what people paid but also what they gained and the experience of the process. Social provision such as health care is relational, and exclusion, inclusion and quality work through social expectations and established patterns of behaviour. Establishing and legitimating claims requires organization, and sectional organizing is not necessarily a zero sum game: it can establish a legitimate tradition to be drawn upon by others.

5 Inequality and redistribution

The general argument of the 'social settlement' literature is a challenging one. It suggests that explicit acceptance of some forms of social inequality has been an important basis for stabilizing substantial redistributive success. This argument is not intended to suggest that some forms of inequality are fine. Rather, it is intended to focus attention on the culturally specific processes whereby redistribution has been actively fought for in different countries, and on the fact that associating rights to make claims for social provision with the construction of citizenship can be both effective and double-edged. Redistribution through social provisioning has never been a 'technical' matter; it has been a crucial element in the fight for democratic governance in countries where it has been effective.

The general argument here is simply for a closer focus in the social policy literature on the political economy of redistribution, including the process of legitimating and strengthening claims to redistributive behaviour, the influences on the distributive outcomes of private/public systems, and the scope for sustaining redistributive behaviour by embedding it in forms of reciprocity. Such a research programme needs to pay close attention – it follows from many of the arguments above – to the discursive construction of social policy; the currently dominant social policy discourse and mindset is a real roadblock for policy makers with redistributive intentions.

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